



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13180

13182

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN TB 134 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						d. STREET ADDRESS 225 BALTIMORE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EFFIE Middle M. Last ABRAHAM				4. DATE OF DEATH Month OCTOBER Day 1 Year 1967					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-14-87		9. AGE (In years just birthday) 80 Yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Head Nurse - County Infirmary Uniontown,				10b. KIND OF BUSINESS OR INDUSTRY PAWNT SAVING, MD.		11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM HARDEN				14. MOTHER'S MAIDEN NAME LAURA SHAFFER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 172-16-5083		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO (b) Carcinoma of the colon DUE TO (c) Anterior Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH 12 mo. 24 mo.	
								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
								PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio sclerotic cardio vascular disease	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 26, 1966, to Oct 1, 1967, that (I) (we) last saw the deceased alive on Oct 1, 1967, and that death occurred at 5:50 P.M. from causes and on the date stated above.									
22a. SIGNATURE 				22b. DATE SIGNED Oct 3, 1967		22c. PHYSICIAN'S NAME (Type) DR. DONALD B. GROVE			
22d. ADDRESS CUMBERLAND, MD.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Mariah Baptist Cemetery		23d. LOCATION (City or Town) (County) (State) Smithfield, Penna.			
24. FUNERAL DIRECTOR John J. Hager, Jr.				25a. REC'D BY REGISTRAR OCT 5 1967		25b. REGISTRAR'S SIGNATURE 			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13183

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS Jackson Street			
3. NAME OF DECEASED (Type or print) First Gilbert Middle R. Last Beeman				4. DATE OF DEATH Month 10 Day 19 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/31/1904	9. AGE (In years last birthday) 63 Yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese Employee			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert Beeman			14. MOTHER'S MAIDEN NAME Janet Beeman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Robert Beeman, Lonaconing, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO CORONARY OCCLUSION (SON) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CORONARY SCLEROSIS (c)				INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 10/19/1967 22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) CUMBERLAND, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/22/1967		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City or town) (County) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR GEORGE EICHHORN				ADDRESS Lonaconing, Md. 21536		25a. REC'D BY REGISTRAR OCT 20 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13182

CERTIFICATE OF DEATH

13184

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 9/15/1967		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary				d. STREET ADDRESS 223 Harrison Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Leon H. Benjamin				4. DATE OF DEATH Month Day Year October 11, 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/18/1882		
				9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Manager			10b. KIND OF BUSINESS OR INDUSTRY Athletic Club		11. BIRTHPLACE (County & State, or foreign country) Cazenova, New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Benjamin				14. MOTHER'S MAIDEN NAME Vernett (Brown)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 208-03-2766		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH yr								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9/15/67 , 19__, to 10/11/67 19__, that (I) (we) last saw the deceased alive on 10/10/67 19__, and that death occurred at P. M. from causes on and the date stated above. at 1:10 P. M., D.S.T.								
22a. SIGNATURE George M. Simons				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/11/1967		
22c. PHYSICIAN'S NAME (Type) George M. Simons, M. D.				22d. ADDRESS Memorial Hospital, Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 14, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Peter Lutheran Cem.		23d. LOCATION (City or Town) (County) (State) Pittsburgh, Allegheny Pa.		
24. FUNERAL DIRECTOR Byron Knight Cumberland, Md.				25a. REC'D BY REGISTRAR DATE OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE
HEALTH DEPT.

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VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13183

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13185

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>Ridgeley</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>4 Carpenters Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Eugene Brant</u>		4. DATE OF DEATH Month Day Year <u>October 28, 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1905</u>
9. AGE (In years last birthday) yrs. <u>62</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Chief Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Tire Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ridgeley, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Owen S. Brant</u>		14. MOTHER'S MAIDEN NAME <u>Retta M. Moats</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-0163</u>	
17. INFORMANT <u>Mrs. Pansy E. Iser</u>		Address <u>Ridgeley, W. Va. 4 Carpenters Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock; Exanguination</u> DUE TO (b) <u>Bleeding Duodenal Ulcer</u> DUE TO (c) <u>"</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		22. DATE SIGNED <u>October 28, 1967</u> Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany, Md.</u>
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		25. RECEIVED BY REGISTRAR <u>NOV 1 1967</u>	

DATE

FILE NO.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13186

FOR STATE
HEALTH DEPT

13184

1. PLACE OF DEATH a. COUNTY Alleganey MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Alleganey	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.		d. STREET ADDRESS 610 Elm Street	
3. NAME OF DECEASED (Type or print) Callie H. Burns		4. DATE OF DEATH Oct. 14, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1887
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	
11. BIRTHPLACE (State or foreign country) Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob E. Burns		14. MOTHER'S MAIDEN NAME Mary Gaver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Memorial Hospital		Address Cumberland Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis; Cor Pulmonale DUE TO (c) Emphysema, Bronchiectasis, Silicosis			INTERVAL BETWEEN ONSET AND DEATH Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED October 14, 1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REBURY (Specify)		23b. DATE THEREOF	
Burial		Oct. 17, 1967	
23c. NAME OF CEMETERY OR CREMATORY Greenmont Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland Md.	
24. FUNERAL DIRECTOR Louis Stein Inc.		ADDRESS Cumberland Md.	
25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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11/1/50

Allegany

Chapel Hill

Memorial Hosp.

Cellis

White

Refined Petroleum

James E. Jones

Bo

Lila

Chapel Hill

110 Elm Street

A. Jones

Feb. 22, 1950

Chapel Hill

Early letter

Memorial Hospital

Chapel Hill, N.C.

As in letter before

Chapel Hill, N.C.

Chapel Hill, N.C.

11/1/50

X

11/1/50

Chapel Hill, N.C.

11/1/50

Chapel Hill, N.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE ALLEGANY b. COUNTY MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY in 1b 2 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS P. O. BOX #27			
3. NAME OF DECEASED (Type or print) First LORETTA Middle L. Last BURNS				4. DATE OF DEATH Month OC T. Day 19 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-31-96		9. AGE (in years last birthday) 71 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ALLEGANY CTY., MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME PATRICK MONAHAN				14. MOTHER'S MAIDEN NAME GREEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO		17. INFORMANT HOSP. RECORD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENO-CA, ABDOMINAL, ORIGINAL SITE UNKNOWN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS							INTERVAL BETWEEN ONSET AND DEATH 5 MOS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-2-56 , 19__, to 10-19-67 , 19__, that (I) (we) last saw the deceased alive on 10-19-67 , 19__, and that death occurred at __ M, from causes and on the date stated above.							
22a. SIGNATURE R. W. Ballin				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) R. W. BALLIN, M. D.	
22d. ADDRESS 62 GREENE ST., CUMBERLAND, MD. 21502		22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/23/1967		23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d. LOCATION (City or Town) (County) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR EICHORN FUNERAL HOME				25a. REC'D BY REGISTRAR OCT 23 1967		25b. REGISTRAR'S SIGNATURE <i>Orlando J. J...</i>	

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13186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

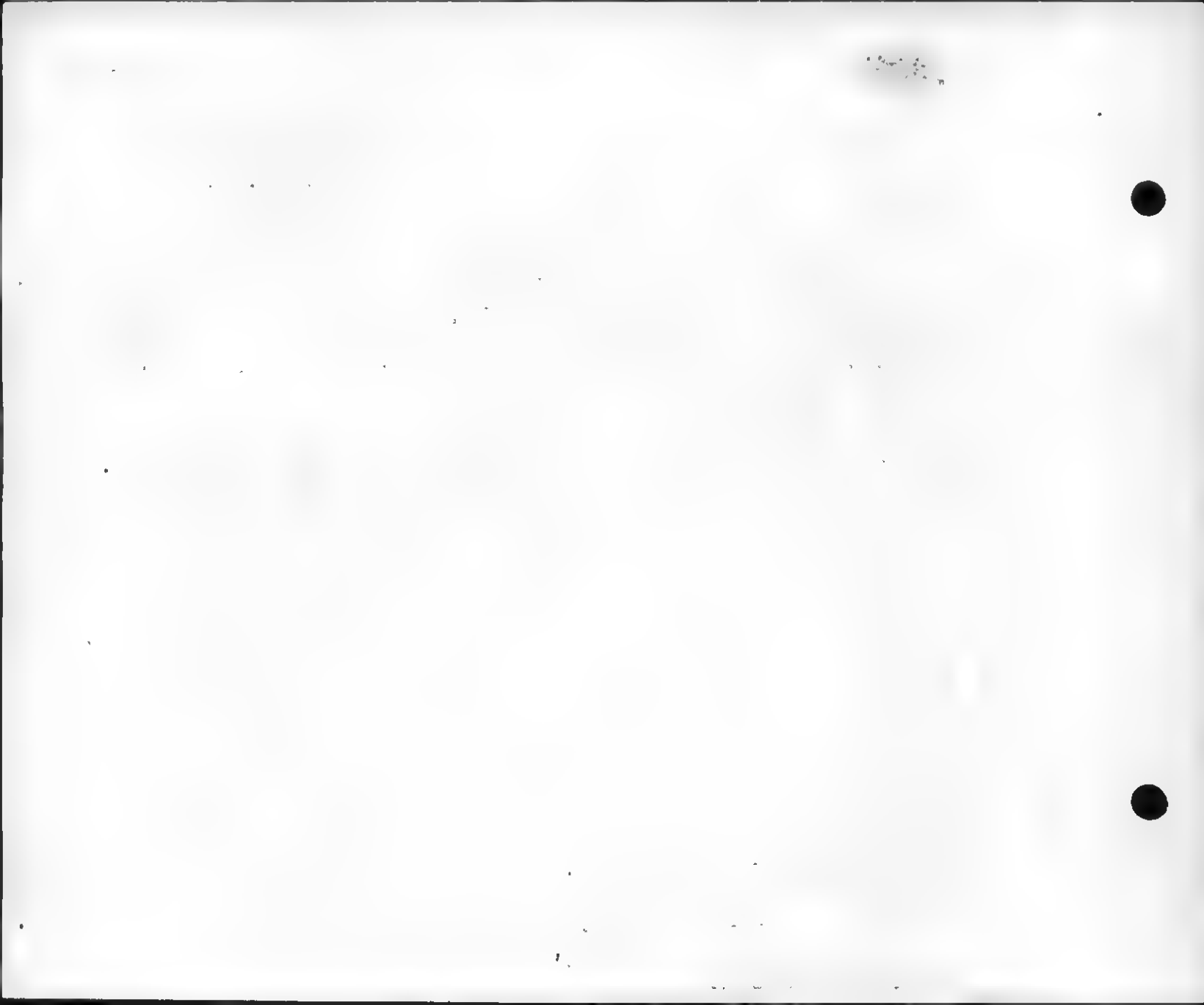
13188

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Eckhart) R.F.D. 2, BOX 40			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D.2, BOX 40, FROSTBURG				d. STREET ADDRESS FROSTBURG			
3. NAME OF DECEASED (Type or print) Anthony Wayne Champ				4. DATE OF DEATH 10 1 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 18, 1967	
9. AGE (In years last birthday) 1		10. IF UNDER 1 YEAR Months 1 Days 12		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N.A.				10b. KIND OF BUSINESS OR INDUSTRY N.A.		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
13. FATHER'S NAME William Lee Champ				14. MOTHER'S MAIDEN NAME Catherine McGuire			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N.A.		16. SOCIAL SECURITY NO. N.A.		17. INFORMANT William Lee Champ Eckhart, Md.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 7544 IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA, CARDIAC FAILURE DUE TO (b) AORTIC ENDOTHELIAL FIBROELSTOSIS DUE TO (c) Congenital				INTERVAL BETWEEN ONSET AND DEATH 15003			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				22. DATE SIGNED OCTOBER 1, 1967			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				Address (Street, city, town, or county) Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-3-67		23c. NAME OF CEMETERY OR CREMATORY Eckhart Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) Allegany Md.	
24. FUNERAL DIRECTOR HAFFER SOWERS FUNERAL HOME 60W. Main				25b. REGISTRAR'S SIGNATURE Charles Judge			
25a. REGISTRAR'S NAME BEULAH H. MONTESANT				25c. DATE OCT 5 1967			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #4 Film #G333 10/11/67 ph

13187

CERTIFICATE OF DEATH

13189

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 7/17/67	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Cumberland) LaVale		d. STREET ADDRESS Rt. 1, Box 61 B, LaVale, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sophia M. Chenowith		4. DATE OF DEATH Month Oct. Day 11 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/19/1881
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME August Thuss		14. MOTHER'S MAIDEN NAME Christine Phillips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599, Cumberland, Md.		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Generalized arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/17/67 , 19__, to 10/11/67 , 19__, that (I) (we) last saw the deceased alive on 10/11/67 19__, and that death occurred at P. M. from causes and on the date stated above.			
22a. SIGNATURE George M. Simons		22b. DATE SIGNED 10/12/1967	
22c. PHYSICIAN'S NAME (Type) George M. Simons, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10/17/67	23c. NAME OF CEMETERY OR CREMATORY Hell Creek Burial Pl.	23d. LOCATION (City or Town) (County) (State) Cumberland Md
24. FUNERAL DIRECTOR Louis Stein Inc. - Cumberland Md.		25a. REC'D BY REGISTRAR OCT 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13190

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegheny	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Monacaoning		c. LENGTH OF STAY IN 1b 1 hour	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Main St.		d. STREET ADDRESS 470 Spruce	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First David Middle Nairn Last Cook		4. DATE OF DEATH Month Oct. Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1907
9. AGE (In years last birthday) 58 yrs.		10. UNDER 1 YEAR Months 58 Days 0 Hours 0 Min. 0	11. UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brake man		10b. KIND OF BUSINESS OR INDUSTRY Rail Road	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Arch Cook	
14. MOTHER'S MAIDEN NAME Mary Wilson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give year or dates of service) WW 2	
16. SOCIAL SECURITY NO. 220 10 2376		17. INFORMANT John Cook Address Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary Sclerosis DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22. DATE SIGNED Oct. 21, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 25, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Peter's
24. FUNERAL DIRECTOR Ed Boul		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE OCT 21 1967			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

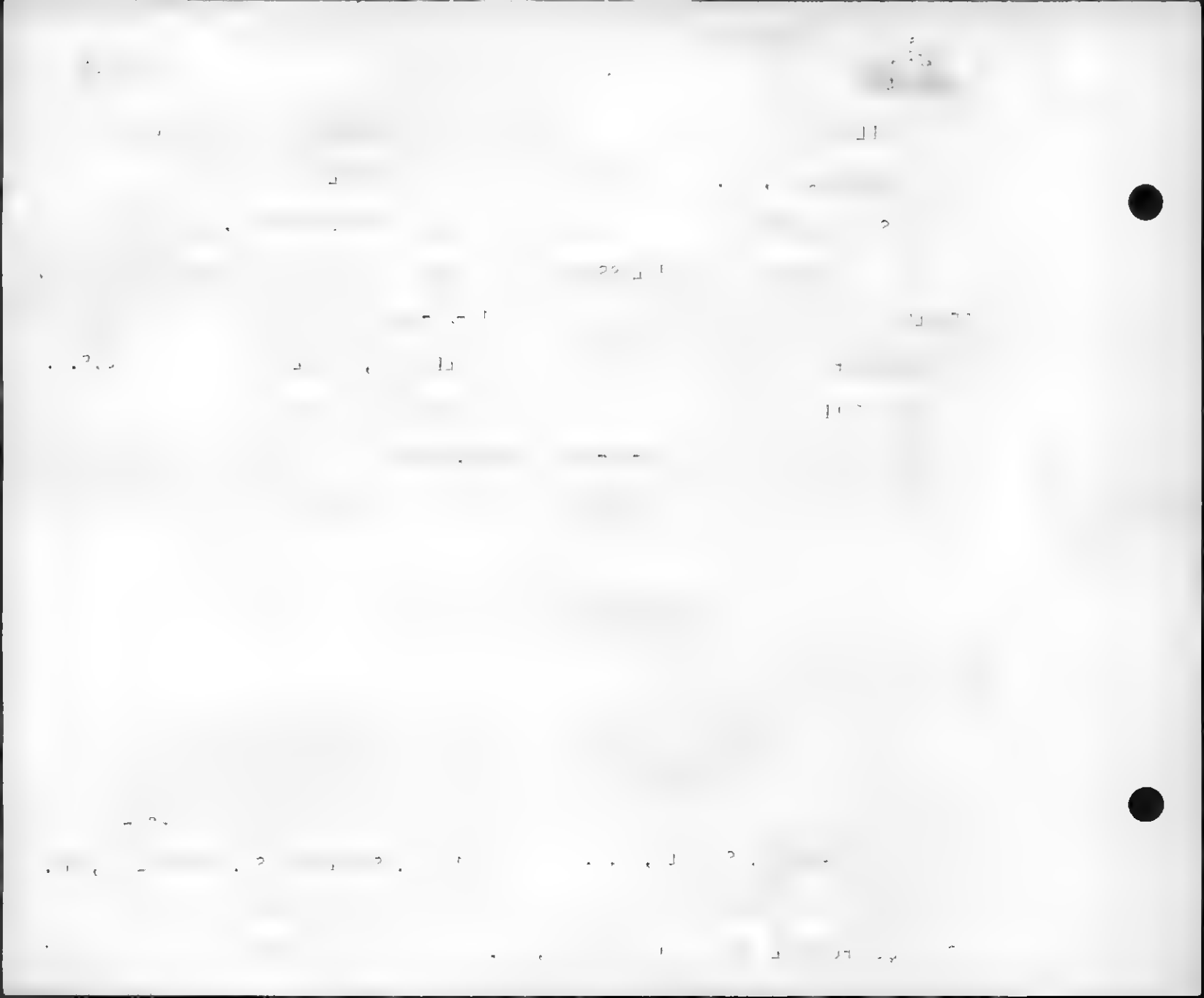
CERTIFICATE OF DEATH

13191

13189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admision) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. LENGTH OF STAY IN 1b 27 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART				e. STREET ADDRESS 726 OLDTOWN RD.			
3. NAME OF DECEASED (Type or print) MARGARET Ellen D'ALESSANDRO				4. DATE OF DEATH Month OCTOBER Day 28 Year 19 67			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-20-02	
9. AGE (In years last birthday) 64 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) ALLEGANY, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME RAYMOND TALLEY			
14. MOTHER'S MAIDEN NAME GREEN (Barbara)				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO 214-05-8847				17. INFORMANT HOSP. RECORD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u><i>Myocardial infarction</i></u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u><i>10/28</i></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u><i>Thrombotic</i></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u><i>10/1</i></u> , 19 <u><i>66</i></u> , to <u><i>10/28</i></u> , 19 <u><i>67</i></u> , that (1) (we) last saw the deceased alive on <u><i>10/28</i></u> 19 <u><i>67</i></u> , and that death occurred at <u><i>10 AM</i></u> , from causes and on the date stated above							
22a. SIGNATURE <u><i>Wayne C. Spiggle</i></u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10-28-67	
22c. PHYSICIAN'S NAME (Type) WAYNE C. SPIGGLE, M.D.				22d. ADDRESS 126 N. SMALLWOOD ST. CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct. 31, 1967		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City or town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME				ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR NOV 1 1967	
				25b. REGISTRAR'S SIGNATURE <u><i>Charles Judge</i></u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13190

CERTIFICATE OF DEATH

13192

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
c. LENGTH OF STAY IN 1b 1 DAY		d. STREET ADDRESS 23 WASHINGTON ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last HUGH DONAHUE		4 DATE OF DEATH Month Day Year OCTOBER 19, 19 67	
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 19, 1890
9 AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TAVERN KEEPER		10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS	
11 BIRTHPLACE (County & State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN DONAHUE		14. MOTHER'S MAIDEN NAME MARY SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 219-14-5980	
17. INFORMANT MRS. ANGELA WEISENBORNE, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure DUE TO (b) Chronic nephritis DUE TO (c) Rheumatoid arthritis		INTERVAL BETWEEN ONSET AND DEATH 3 months -	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 10, 19 67 to Oct 19 19 67 that (I) (we) last saw the deceased alive on Oct 19 19 67 and that death occurred at 11 A.M. from causes and on the date stated above			
22a. SIGNATURE John B. Davis, MD		22b. DATE SIGNED 10/20/67	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.		22d. ADDRESS 5 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR OCT 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



13191

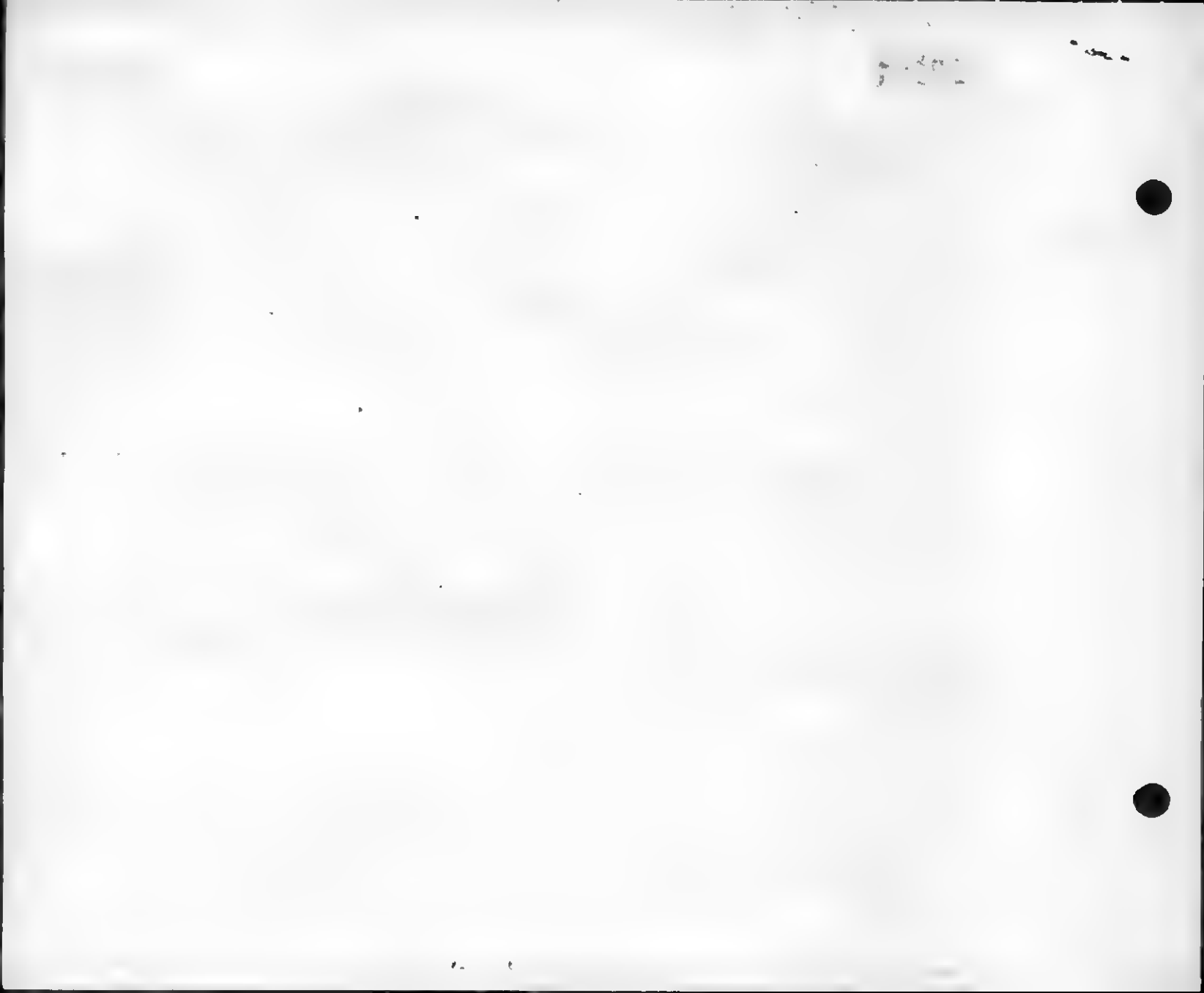
CERTIFICATE OF DEATH

13193

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St Marys Terrace		d. STREET ADDRESS St. Marys Terrace	
3 NAME OF DECEASED (Type or print) First Nicholson Middle Eilbeck Last Eilbeck		4. DATE OF DEATH Month 10 Day 9 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/24/1893
9 AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months 7 Days 4 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Merchant	
11 BIRTHPLACE (County & State, or foreign country) Pekin, Md.		12. CIT ZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nicholson Eilbeck		14. MOTHER'S MAIDEN NAME Mary J. Perry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Gertrude Eilbeck Lonaconing, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO (b) Cardiomegaly DUE TO (c) Atherosclerotic CV disease		INTERVAL BETWEEN ONSET AND DEATH years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Pulmonary fibrosis, emphysema, asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1965 to Oct. 9, 1967 , that (I) (we) last saw the deceased alive on Oct 3 1967 , and that death occurred at 7 P.M. from causes and on the date stated above.			
22a. SIGNATURE L.R. Miles Jr MD		22b. DATE SIGNED 10.10.67	
22c. PHYSICIAN'S NAME (Type) L.R. MILES JR, MD		22d. ADDRESS LONA CONING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/1967	
23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Moscow, Md.	
24. FUNERAL DIRECTOR George Eichhorn		25a. RECEIVED BY REGISTRAR OCT 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Lonaconing, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 316 GRAND AVENUE,	
3. NAME OF DECEASED (Type or print) First FLOYD Middle R. Last ENGLE		4. DATE OF DEATH Month OCT. Day 22 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1893
9. AGE (In years (rthday) yrs) 74		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired Watchman		10b. KIND OF BUSINESS OR INDUSTRY Queen Glass Factory	
11. BIRTHPLACE (County & State or foreign country) W. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM ENGLE		14. MOTHER'S MAIDEN NAME RACHAEL FISHELL *CATHERINE FISHELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-10-1560A	
17. INFORMANT MEMORIAL HOSPITAL- CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Bronchectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) myocarditis c. Decomposition DUE TO 3 weeks (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 19 7:00 P.M. that (I) (we) lost saw the deceased alive on 19 , and that death occurred at 10/22/67 M. from causes and on the date stated above			
22a. SIGNATURE Clay E. Durrett		22b. DATE SIGNED 10/22/67	
22c. PHYSICIAN'S NAME (Type) DR/ CLAY E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/67	
23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg Alleg Md.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR John J. Hafer, Jr.	
25b. REGISTRAR'S SIGNATURE John J. Hafer, Jr.		DATE OCT 24 1967	



13196

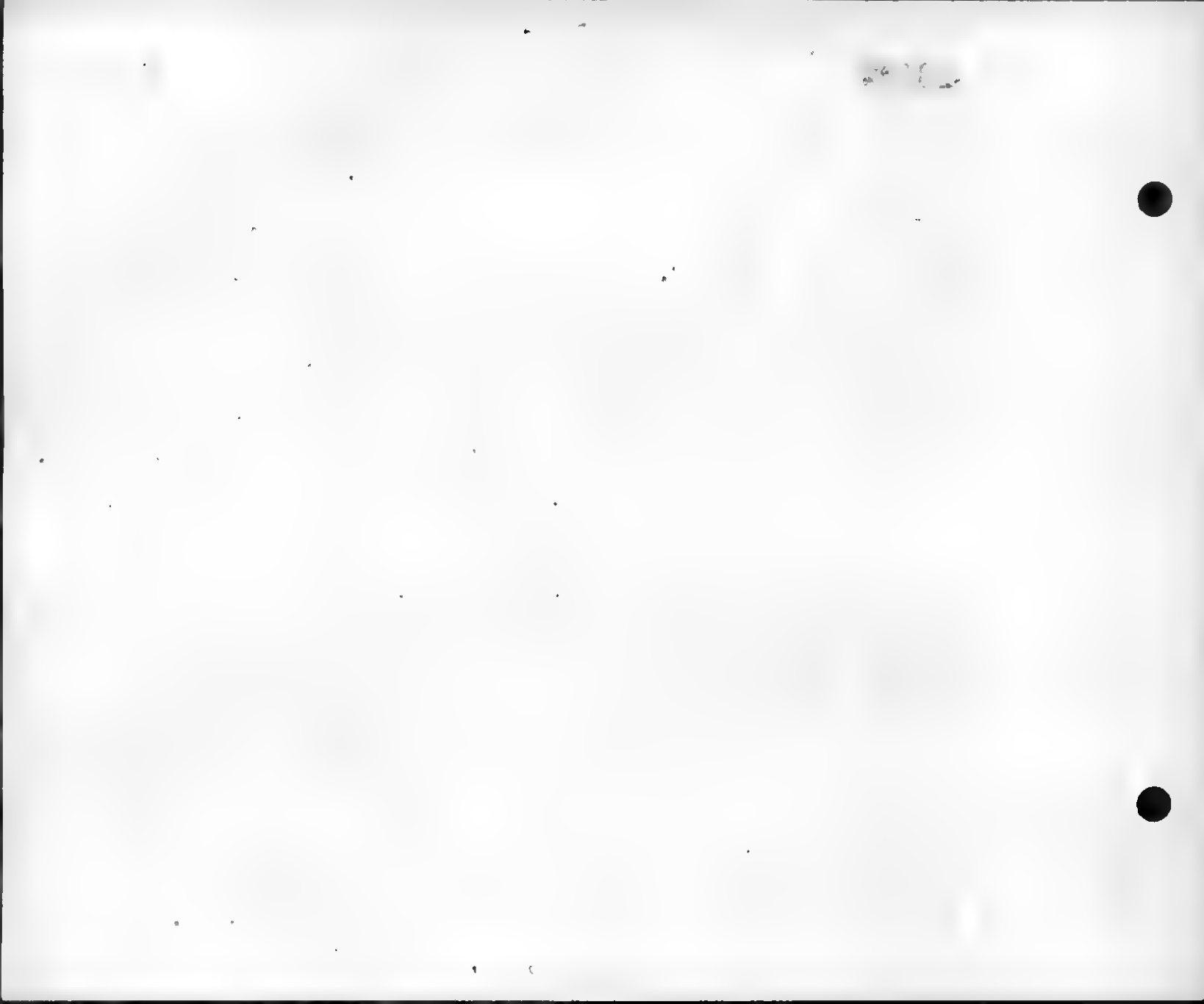
CERTIFICATE OF DEATH

13195

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Lonaconing		c LENGTH OF STAY IN 1b 68yrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Charlestown, St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JOHN N. GARDNER		4 DATE OF DEATH 10/20/1967	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/1898
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State or foreign country) Lonaconing, Md.
13. FATHER'S NAME William Gardner		14. MOTHER'S MAIDEN NAME Sarah Jane Gardner	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Margaret Gardner		Address Lonaconing, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Coronary Insufficiency DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH hrs. years years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchial asthma + emphysema			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 19, 1967 , to Oct 20, 1967 that (I) (we) last saw the deceased alive on Oct. 19, 1967 , and that death occurred at 1 P.M. from causes and on the date stated above			
22a SIGNATURE L.R. Miles Jr.		22b DATE SIGNED 10.21.67	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.		22d ADDRESS LONACONING MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/23/1967	23c NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	23d LOCATION (City or Town) (County) (State) Moscow, Md.
24 FUNERAL DIRECTOR George Eichhorn		25a REC'D BY REGISTRAR Oct 23 1967	
ADDRESS Lonaconing, Md.		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13194

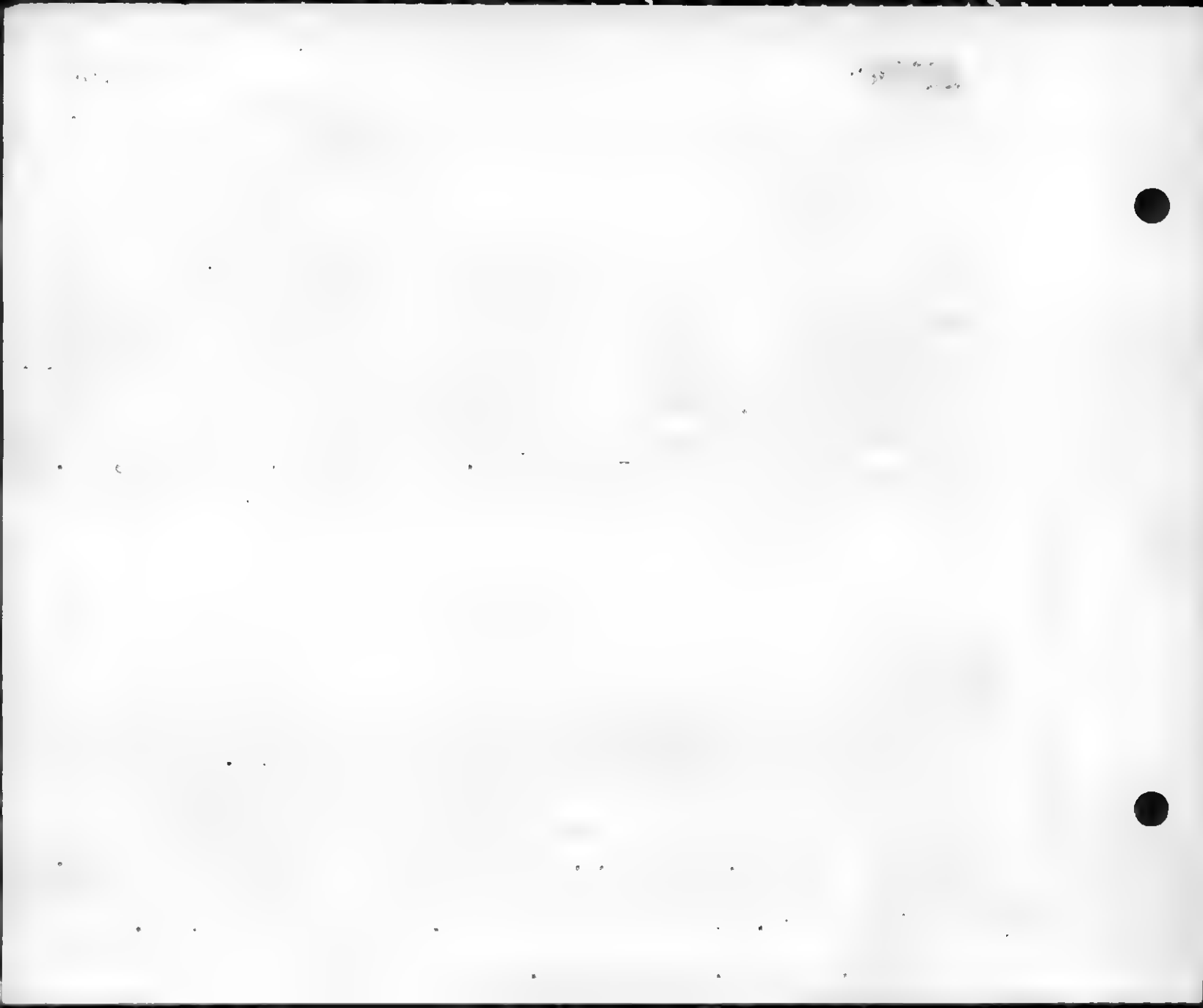
CERTIFICATE OF DEATH

13196

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS ROUTE # 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SYLVAN RETREAT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle THOMAS Last GEIGER		4. DATE OF DEATH Month OCTOBER Day 8 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/83
9. AGE (in years lost birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Uriah M. Geiger	
14. MOTHER'S MAIDEN NAME Lydia Knepp		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 712-14-1625		17. INFORMANT Mr. Oklen Geiger, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral - vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 15, 1967 , to Oct. 8, 1967 , that (I) (we) last saw the deceased alive on Oct. 8, 1967 , and that death occurred at 11 P.M. , from causes and on the date stated above.			
22a. SIGNATURE George M. Simons		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) George M. Simons, M.D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Gardens La Vale, Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.		25a. REC'D BY REGISTRAR DATE OCT 16 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

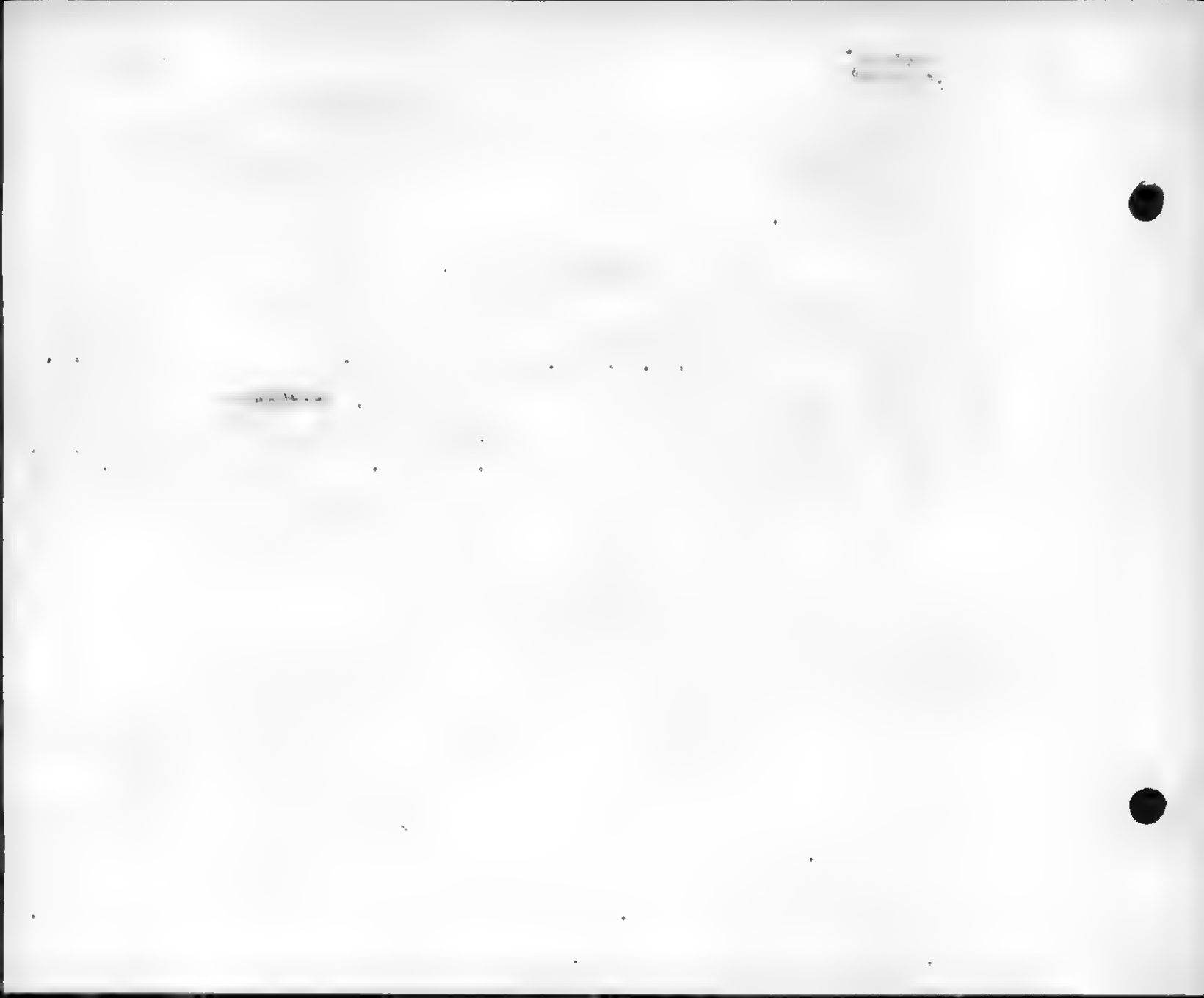
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13195

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First CHARLES Middle Frederick Last GINNIMAN		4 DATE OF DEATH Month OCT Day 9 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-98
9 AGE (In years last birthday) 68 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder	10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.
11 BIRTHPLACE (County & State, or foreign country) CUMB, MD.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY GINNIMAN		14 MOTHER'S MAIDEN NAME IDA E. Brothorn	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL Address Mrs. Edith M. Ginniman 112 Utah Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO (b) Arteriosclerosis - generalized DUE TO (c) Squamous carcinoma - left lower leg - amputated June 67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Squamous carcinoma - left lower leg - amputated June 67		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/4 , 1967, to 10/9 , 1967, that (I) (we) last saw the deceased alive on 10/9 , 1967, and that death occurred at 1:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Lewis		22b. DATE SIGNED 10/11/67	
22c. PHYSICIAN'S NAME (Type) DR. TIMOTHY LEWIS		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/12/67	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.		25a. REC'D BY REGISTRAR OCT 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13196

CERTIFICATE OF DEATH

13198

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN TB 9 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 202 AVE. M.			
3. NAME OF DECEASED (Type or print) First GEORGE Middle B Last GROVE				4. DATE OF DEATH Month 10 Day 02 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-86		9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 02 Days 02 Hours 19 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY TEXTILE FACTORY		11. BIRTHPLACE (County & State, or foreign country) GARRETT COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NORMAN				14. MOTHER'S MAIDEN NAME SARAH UPHOLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-14-7070		17. INFORMANT HOSPITAL RECORD, 200 SETON DR., CUMB., MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 7201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive heart failure.						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred on _____ M, from causes and on the date stated above.							
22a. SIGNATURE Clarence J. Vincent				22b. DATE SIGNED 10/3/67		22c. PHYSICIAN'S NAME (Type) CLARENCE J. VINCENT, M. D.	
22d. ADDRESS 126 N. SMALLWOOD ST., CUMBERLAND, MD.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 4 '67		23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		23d. LOCATION (City or town) (County) (State) GARRETT COUNTY, MD.	
24. FUNERAL DIRECTOR DURST FUNERAL HOME, FROSTBURG, MD.				25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13197

CERTIFICATE OF DEATH

13199

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and _____) CUMBERLAND			c. LENGTH OF STAY IN 1b 26 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 209 POTOMAC STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CURTIS A. HAWSE				4. DATE OF DEATH Month Day Year 10 12 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-15-93 1893		9. AGE (In years birthday) yrs 74	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during 1 week preceding death) RAILROAD WORKER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA Oak		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME ROSS ENOS HAWSE				14. MOTHER'S MAIDEN NAME MOLLY HOKE (Mary)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT HOSPITAL RECORD Address 200 SETON DRIVE, CUMB.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4-1 DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>unk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9-18-</u> , 1967, to <u>10-12</u> 1967, that (I) (we) last saw the deceased alive on <u>10-12</u> 1967, and that death occurred at <u>10:40</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/12/67	
22c. PHYSICIAN'S NAME (Type) J.A. PAGAN, M.D.				22d. ADDRESS 5 POTOMAC ST., RIDGELEY, W.V.A.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-15-1967		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Ma.				25a. REC'D BY REGISTRAR DATE OCT 17 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

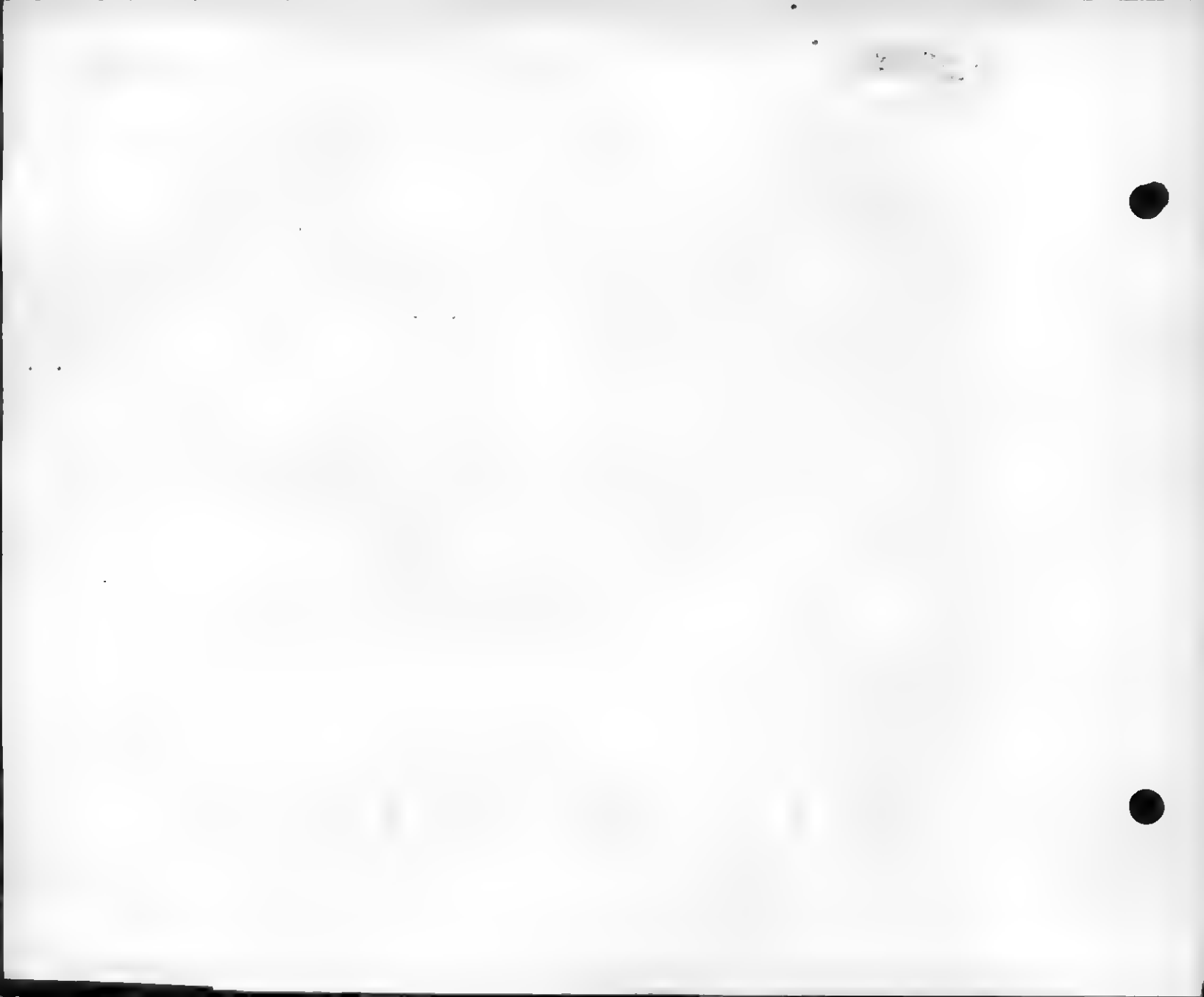
13198

CERTIFICATE OF DEATH

13200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN IT 12 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 228 BOND ST.	
3. NAME OF DECEASED (Type or print) First HARVEY Middle C Last HENDRICKSON		4. DATE OF DEATH Month OCT Day 10 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-06
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) trimmer		10b. KIND OF BUSINESS OR INDUSTRY fire	
11. BIRTHPLACE (County & State, or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARVEY HENDRICKSON		14. MOTHER'S MAIDEN NAME HATTIE BOOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-05-5151	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RENAL FAILURE DUE TO (b) INFERIOR VENA CAVA OBSTRUCTION DUE TO (c) MASSIVE RETROPERITONEAL SARCOMA		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 4 weeks 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) METASTATIC SARCOMA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MED. CA. EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-28-67 , 19 67 , to 10-10 , 19 67 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 3:35 AM , from causes and on the date stated above.			
22a. SIGNATURE Richard E. Schindler M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. RICHARD SCHINDLER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-13-67	
23c. NAME OF CEMETERY OR CREMATORY Sun Set Mon. Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR Robert H. Fritz, Jr. Hitzmiller, Md.		25. REC'D BY REGISTRAR Charles Judge	
25a. DATE OCT 17 1967		25b. REGISTRAR SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13195

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

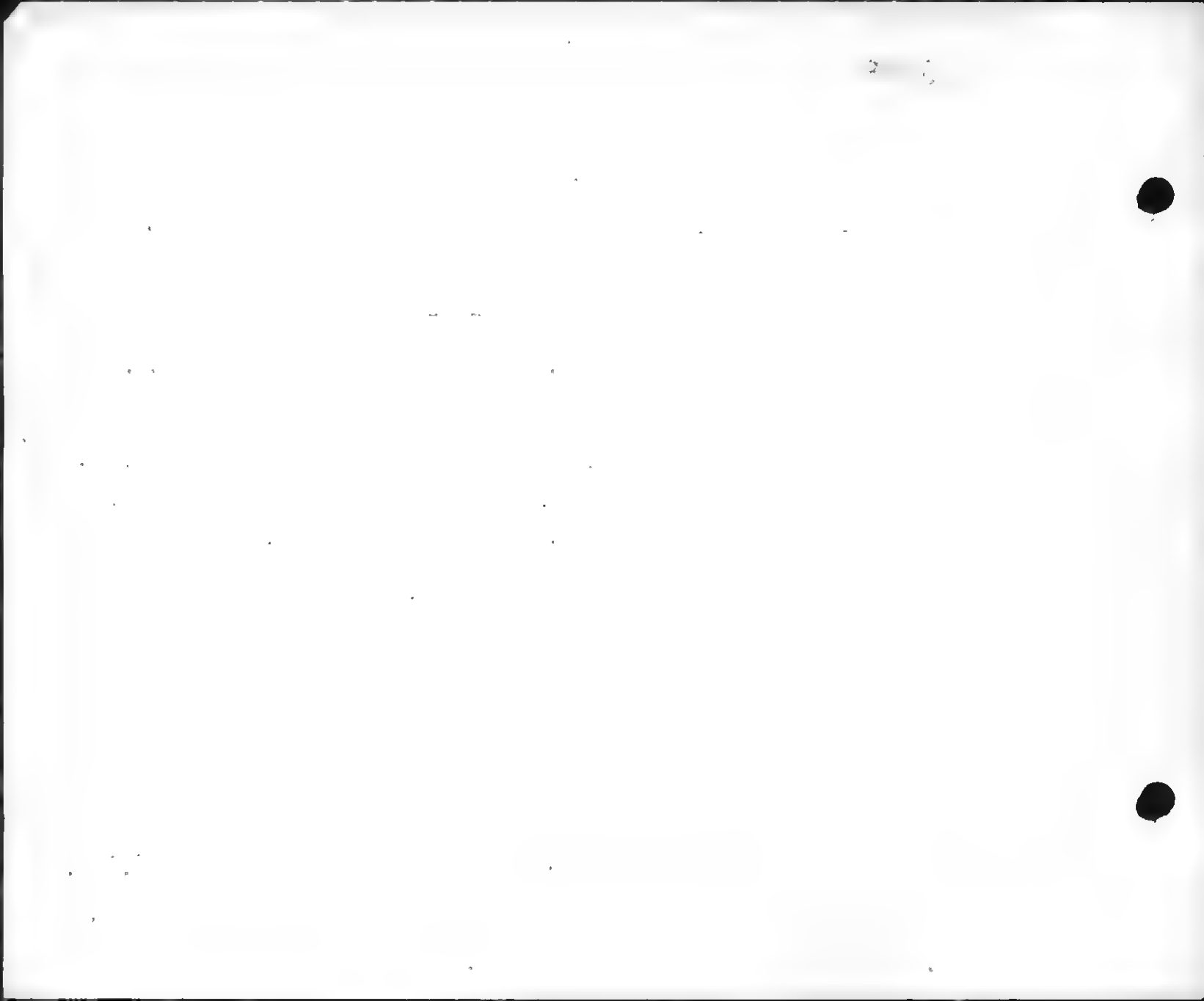
13201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Allegany MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE Maryland b COUNTY Allegany			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN 1b D.O.A.		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital, DOA				d STREET ADDRESS 431 Independence St.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Harold Franklin Hershberger				4 DATE OF DEATH Month Day Year October 31 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 3-30-21		9 AGE (In years last birthday) 46 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b KIND OF BUSINESS OR INDUSTRY City Fire Dept.		11 BIRTHPLACE (State or foreign country) Holsopple, Penna.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Albert Hershberger				14 MOTHER'S MARDEN NAME Carrie Helsel			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of serv. ce) Yes WWII		16 SOCIAL SECURITY NO 220-10-4931		17 INFORMANT Mrs. Helen Hershberger			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Occlusion, Left Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Coronary Thrombosis, Left (c) Coronary Sclerosis, generalized						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED October 31, 1967	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11-3-67		23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24 FUNERAL DIRECTOR H. Lee Silcox				25a REC'D BY REG. STRAR DATE NOV 3 1967		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

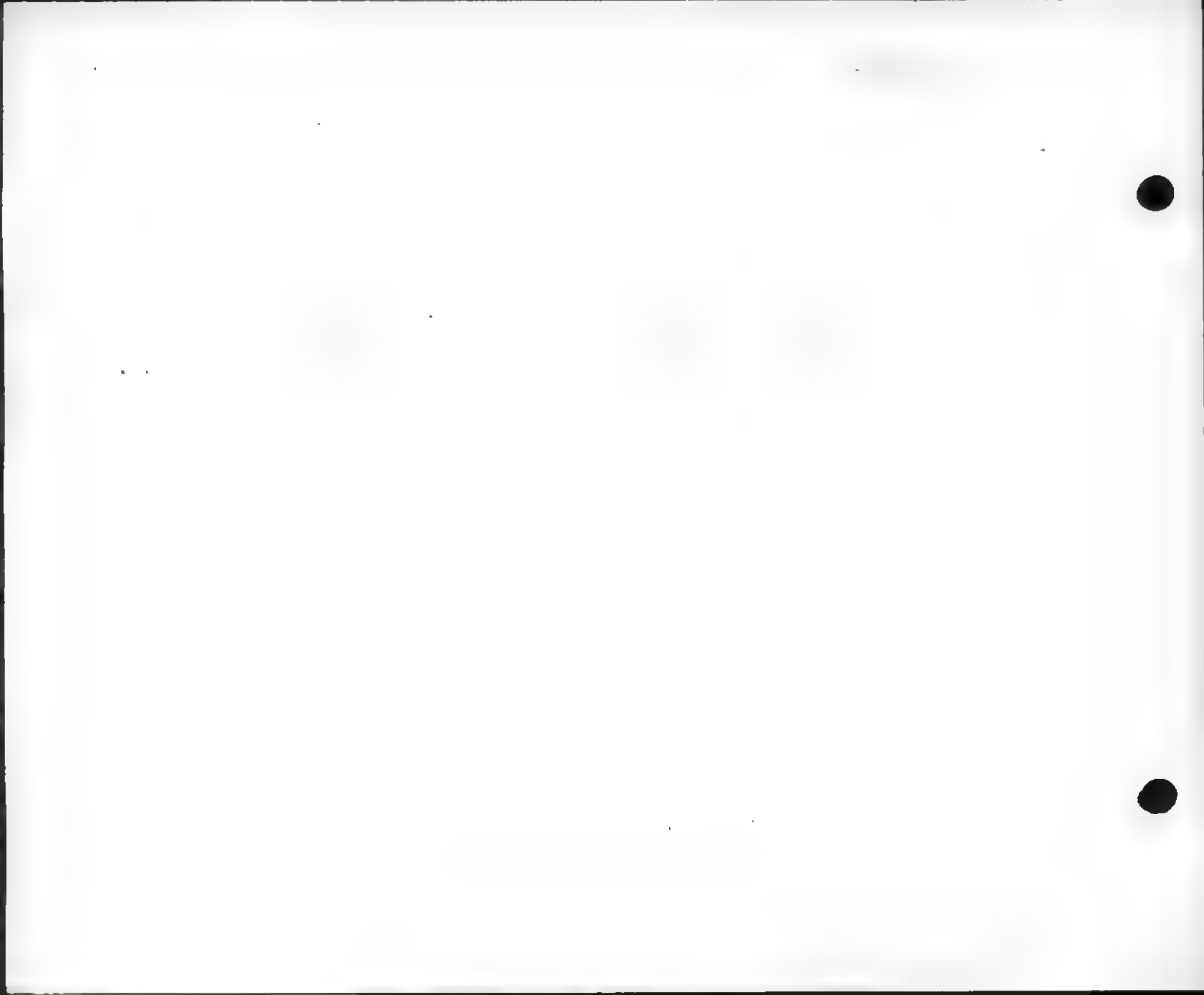
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13202

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived 1 inst lnt an Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits write RJRAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 40 McCULLOH STREET		d. STREET ADDRESS 40 McCULLOH STREET	
3 NAME OF DECEASED (Type or print) First MABEL Middle E. Last HUSSELBAUGH		4 DATE OF DEATH Month OCTOBER Day 14 Year 19 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 10, 1925
9 AGE (In years last birthday) 42 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES CLERK	
10b KIND OF BUSINESS OR INDUSTRY DEPARTMENT STORE		11 BIRTHPLACE (State or foreign country) MARYLAND	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME DENZEL CROWE	
14 MOTHER'S MAIDEN NAME ANNA EISLER		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO 215-20-5062		17. INFORMANT FRED HUSSELBAUGH, FROSTBURG, MD.	
18 CAUSE OF DEATH (Enter on y one cause per ne for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Convulsions DUE TO (b) Cerebral Pressure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Brain Tumor, probable		INTERVAL BETWEEN ONSET AND DEATH Minutes Months ?	
PART II OTHER SIGNIF CANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitaralic MD EXAMINER'S NAME (Type) BENEDICT SKITARELIC MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 14, 1967 Address (Street, city, town, or county) Chamberland, Md.	
22. DATE SIGNED			
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF OCT. 17 '67	23c NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK	23d LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24 FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a REC'D BY REGISTRAR DATE OCT 17 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13205

CERTIFICATE OF DEATH

13203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS 17HRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS 15 ALTA MONT TERRACE	
3 NAME OF DECEASED (Type or print) First ARCH Middle JOHNSON Last JOHNSON		4. DATE OF DEATH Month OCTOBER Day 25 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-2-1899
9 AGE (In years last birthday) 68 yrs		10. UNDER 1 YEAR Months 00 Days 00 Hours 00 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bartender		10b. KIND OF BUSINESS OR INDUSTRY Brunswick Bar	
11 BIRTHPLACE (County & State, or foreign country) LONA CONING, MD.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DANIEL JOHNSON		14. MOTHER'S MAIDEN NAME JANET CLARK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 219-03-8606	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1967 to Oct. 25, 1967 that (I) (we) last saw the deceased alive on Oct 24, 1967 and that death occurred at 5:05 AM from causes and on the date stated above			
22a. SIGNATURE DR. BLANE SCHINDLER		22b. DATE SIGNED 10/25/67	
22c. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER		22d. ADDRESS 43 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/1967	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Md.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR OCT 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 230 Balto Ave., Cumberland Md.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13202

CERTIFICATE OF DEATH

13204

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 52 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 23 OFFUTT ST.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROBERT Middle Louis Last KEMP				4. DATE OF DEATH Month OCT Day 9 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-1915		9. AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT KEMP				14. MOTHER'S MAIDEN NAME BLANCHE BRIDGE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage DUE TO (b) Peptic Ulcer DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease, Cong Heart Failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/18 19 67 to 10/9 19 67 , that (I) (we) last saw the deceased alive on 10/9 19 67 , and that death occurred at 3:15P M, from causes and on the date stated above.							
22a. SIGNATURE I. Dross				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/12/67	
22c. PHYSICIAN'S NAME (Type) DR. I. DROSS				22d. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/67		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.				25a. REC'D BY REGISTRAR DATE OCT 16 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper - Pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

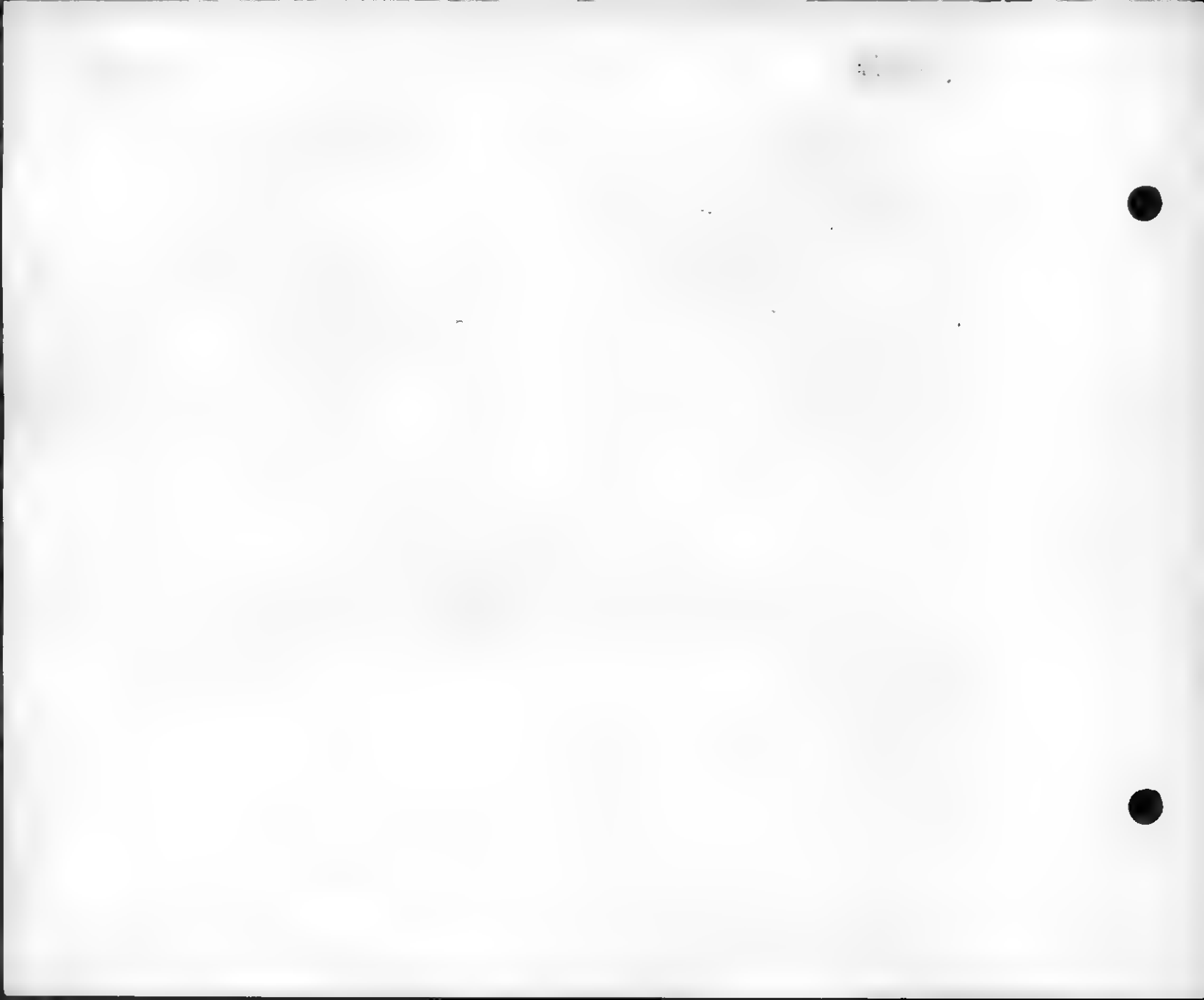
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13202

CERTIFICATE OF DEATH

13205

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 12 GRANT STREET	
3 NAME OF DECEASED (Type or print) First MARGARET Middle KRAUSE Last KRAUSE		4. DATE OF DEATH Month OCTOBER Day 21 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-2-1883
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) WILKES BARRE, PENNA.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RICHARD HARRIS		14. MOTHER'S MAIDEN NAME ELIZABETH RICHARDS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) irreversible shock 576X DUE TO (b) severe septicemia DUE TO (c) Peritonitis & H.V. infection		INTERVAL BETWEEN ONSET AND DEATH 14 hrs 14-16 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/20 , 19 67 , to 10/21 , 19 67 , that (I) (we) last saw the deceased alive on 10/21 , 19 67 , and that death occurred at 9:37 PM on causes and on the date stated above.			
22a. SIGNATURE Walter M. Himmler		22b. DATE SIGNED 10/24/67	
22c. PHYSICIAN'S NAME (Type) WALTER HIMMLER, M.D.		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-24-67	23c. NAME OF CEMETERY OR CREMATORY FB'G. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEGANY, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,		25a. REC'D BY REGISTRAR OCT 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

13204

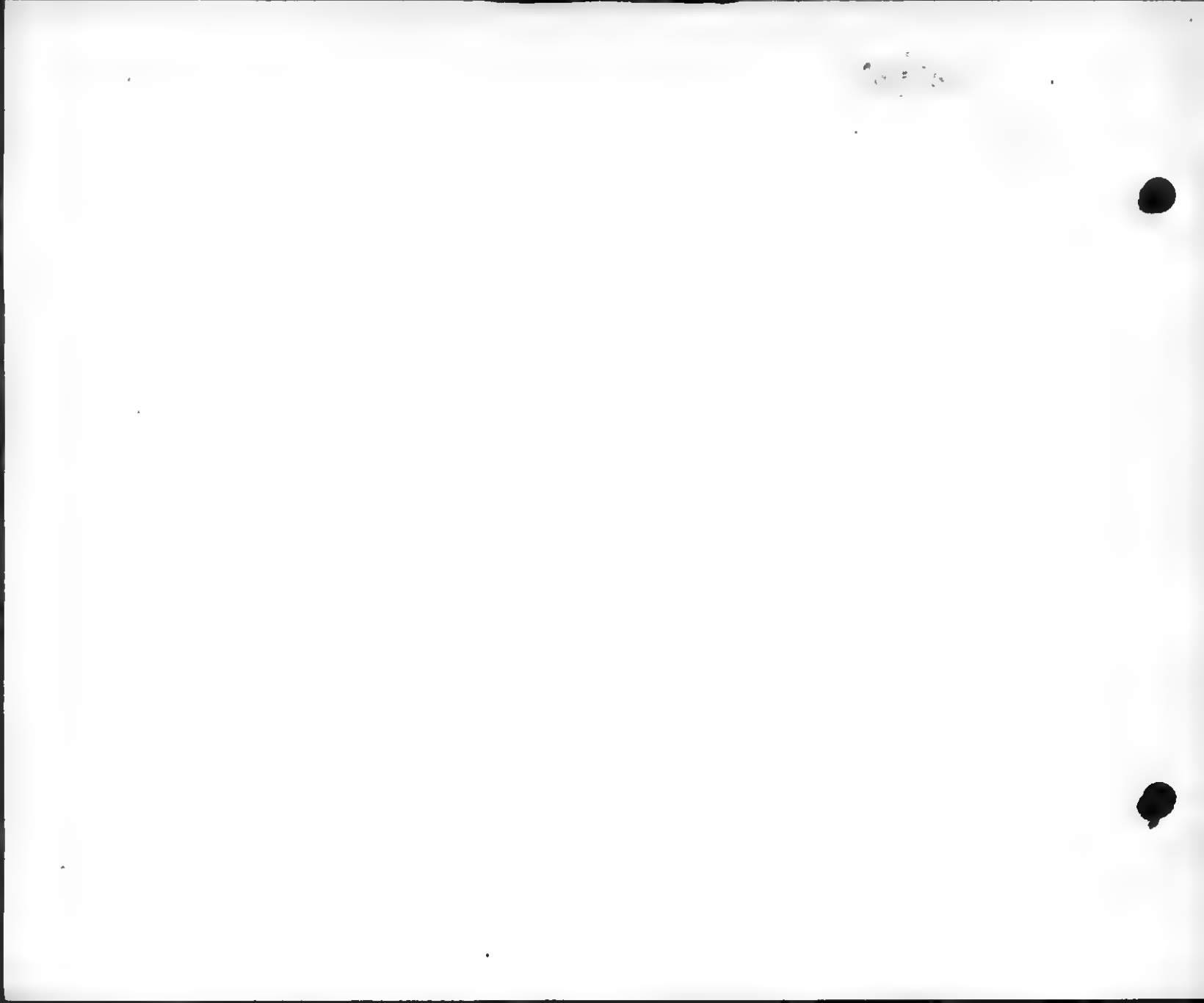
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13206

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write R.R.A. and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 622 N. CENTRE STREET	
3. NAME OF DECEASED (Type or print) First Middle Last EMMA J. LINDNER		4. DATE OF DEATH Month Day Year OCT. 12 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 15, 1880
9. AGE (in years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. HARLEY C. WAGONER		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LOBAR PNEUMONIA DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (d) _____			INTERVAL BETWEEN ONSET AND DEATH 3-4 DAYS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE OF RIGHT HIP			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) FELL AT HOME	
20c. TIME OF INJURY Month Day Year Hour 2:30 pm 9/18 19 67		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) HOME	
20e. (City or town) (County) (State) CUMBERLAND ALLEGANY MD.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitaralic</i> M.D.		22. DATE SIGNED OCT. 12, 1967	
EXAMINER'S NAME (Type) BENEDICT SKITARALIC, M.D.		CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 14, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. PETER & PAUL CEMETERY CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR Charles Judge	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



13205

CERTIFICATE OF DEATH

13207

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY In 1b 34 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 428 FAYETTE STREET	
3 NAME OF DECEASED (Type or print) ROY C. LOTTIG		4 DATE OF DEATH Month 10 Day 10 Year 19 67			
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-03	9 AGE (In years last birthday) 63 yrs	10 IF UNDER 1 YEAR Months 10 Days 19 Hours 67 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10b. KIND OF BUSINESS OR IND. STRY COCA-COLA		11 BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND	
13. FATHER'S NAME HENRY H. Lottig			14. MOTHER'S MAIDEN NAME AGNES (WILLIAMS)		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 214-05-5238		17 INFORMANT HOSPITAL RECORD - 200 SETON DRIVE, CUMB.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) premia with Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Hypertension Mellitus DUE TO (b) Hypertension U.V. Disease (c) Hypertension U.V. Disease					INTERVAL BETWEEN ONSET AND DEATH 3 months year year
PART I OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from July 15, 1967 to July 16, 1967 , that (I) (we) last saw the deceased alive on July 16, 1967 and that death occurred at 12:00 P.M. from causes and on the date stated above.					
22a SIGNATURE Blaine Schindler		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) BLAINE SCHINDLER, M.D.		22d ADDRESS 43 GREENE ST., CUMB., MD. 21502			
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 10/13/67	23c NAME OF CEMETERY OR CREMATORY Hillcrest Burial Ph.	23d LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md		25a REC'D BY REGISTRAR DATE OCT 16 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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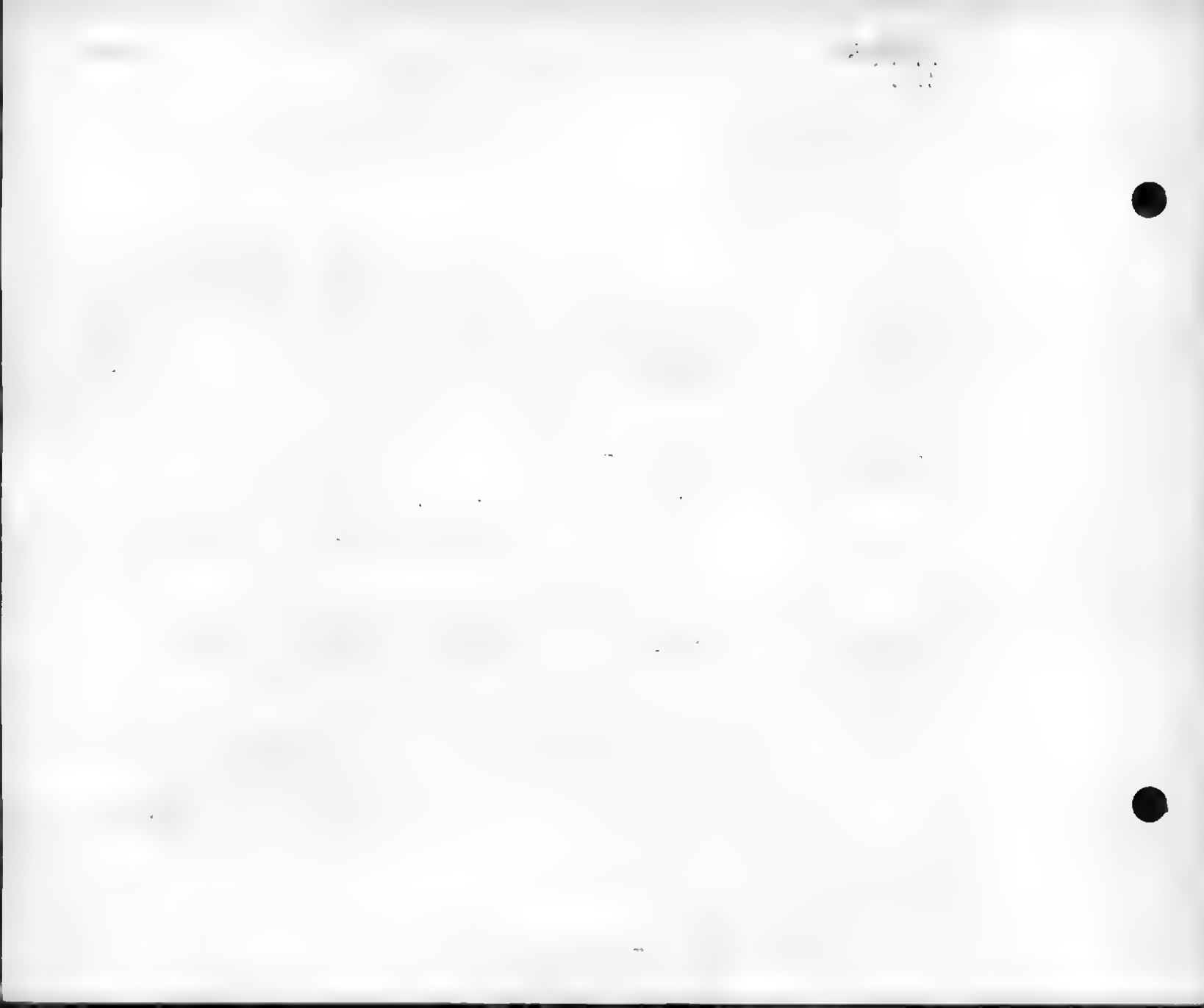
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13206

CERTIFICATE OF DEATH

13208

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 73 HILL STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS FROSTBURG	
3. NAME OF DECEASED (Type or print) First NELLIE Middle MAE Last LOVE		4. DATE OF DEATH Month OCTOBER Day 4 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 7, 1894
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR* Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) SHAFT, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN ORT		14. MOTHER'S MAIDEN NAME JEAN CHAPMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N.A.		16. SOCIAL SECURITY NO 215-20-6790	
17. INFORMANT MRS. LAWRENCE SWEITZER		18. FROSTBURG, MD. 73 HILL ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) 20 yr.			INTERVAL BETWEEN ONSET AND DEATH 4 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystostomy Post operative, 8 days.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 12, 1967 , to Sept 5, 1967 , that (I) last saw the deceased alive on Sept 5, 1967 , and that death occurred at 8:20 PM , from causes and on the date stated above			
22a. SIGNATURE Alvin J. Walters		22b. DATE SIGNED Oct 6, 1967	
22c. PHYSICIAN'S NAME (Type) ALVIN J. WALTERS, M.D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 7, 1967	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK	23d. LOCATION (City or town) (County) (State) FROSTBURG, MARYLAND
24. FUNERAL DIRECTOR MARILOU M. SOWERS		25a. REC'D BY REGISTRAR OCT 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/66

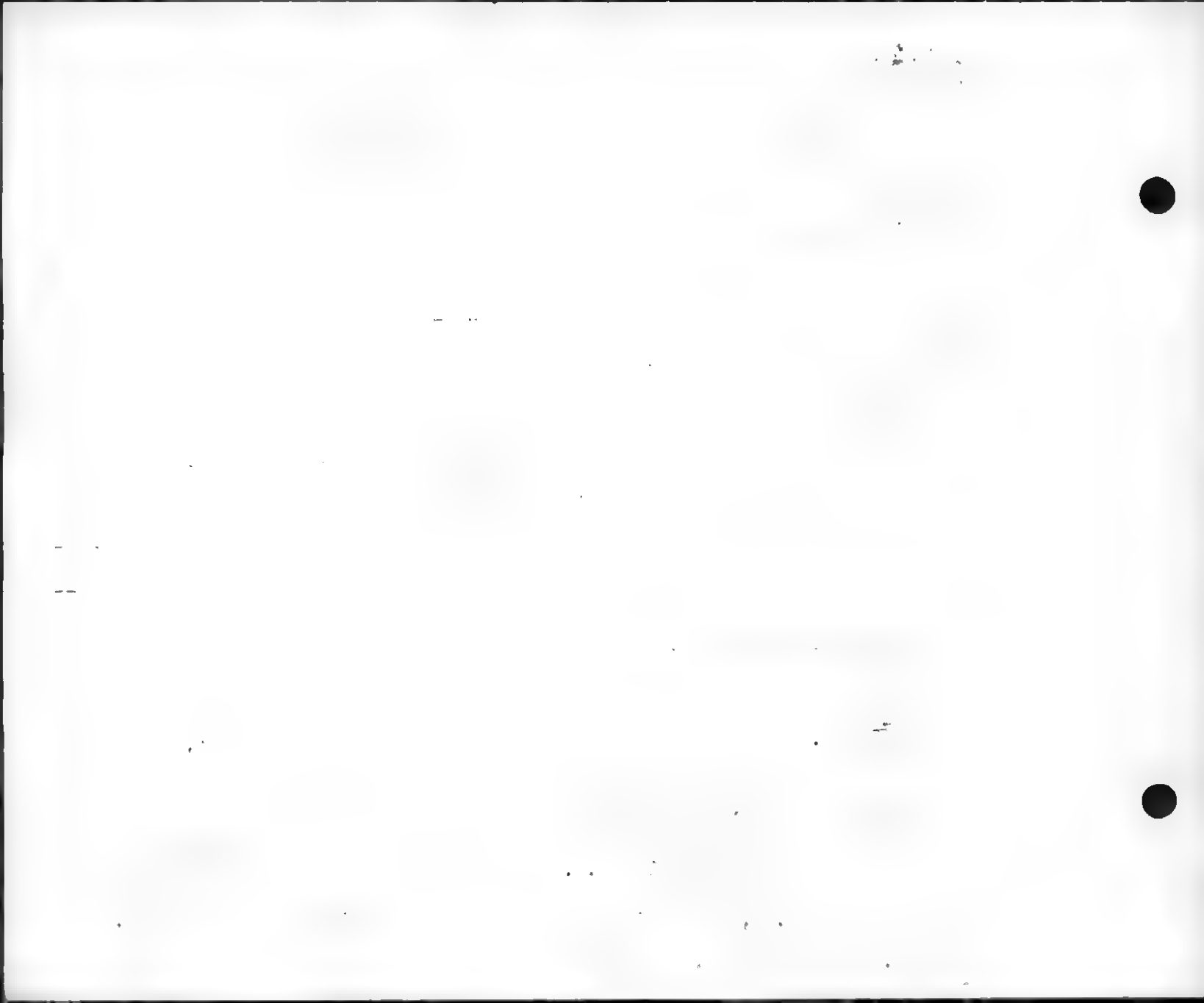
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13207

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13209

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY N 1b 29 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Edith Middle V Last Mann		4 DATE OF DEATH Month October Day 10 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-17-1879
9 AGE (In years last birthday) yrs 87		10 IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Alfred Creek		14 MOTHER'S MAIDEN NAME Rebecca Roberts	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO.	
17 INFORMANT Memorial Hospital-Cumberland, Maryland		Address	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Chronic Myocarditis stating the underlying cause last. (c) ASCV Disease		INTERVAL BETWEEN ONSET AND DEATH 29 Days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Comminuted Intertrochanteric Fracture of Left Hip		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Fell At Home	
20c TIME OF INJURY Month, Day, Year 12:15 p.m. Sept. 9 19 67		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg etc.) Home		20f (City or town) (County) (State) Little Orleans, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		22. DATE SIGNED October 10, 1967 Address (Street, city, town, or county) Cumberland, Maryland	
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF Oct. 13, 1967	23c NAME OF CEMETERY OR CREMATORY Piney Plains	23d LOCATION (City or Town) (County) (State) Little Orleans, Alleg. Md.
24 FUNERAL DIRECTOR Howard J. Grove, Hancock, Maryland		25a REC'D BY REGISTRAR DATE OCT 16 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

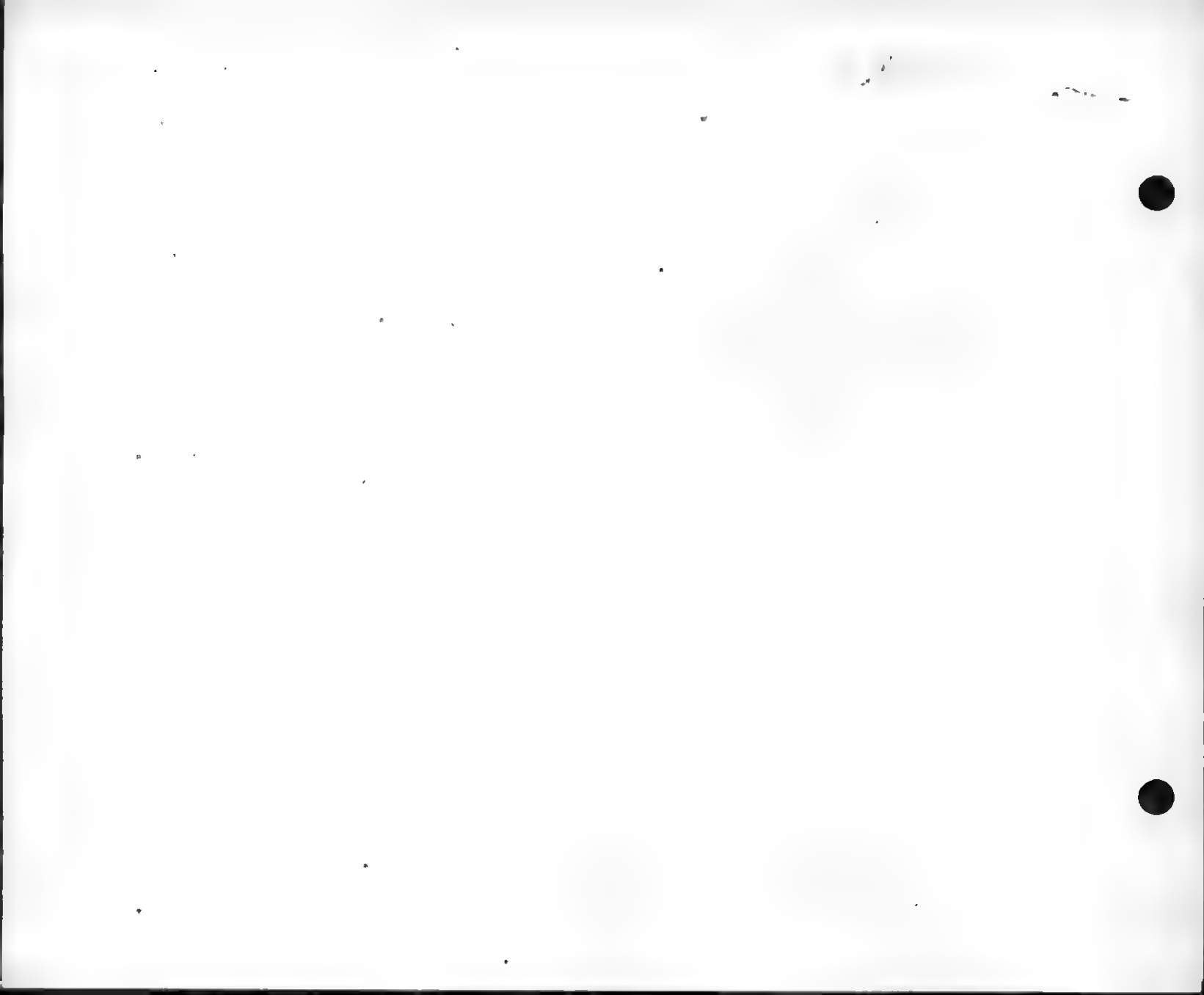
13210

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY MIDDLE Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c LENGTH OF STAY IN 1b Midland	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cemetery Road		d STREET ADDRESS Cemetery Road	
3 NAME OF DECEASED (Type or print) MARY J. McGee		4 DATE OF DEATH Month 10 / Day 9 / Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug, 25th. 1884
9 AGE (In years last birthday) 83 yrs		10 UNDER 1 YEAR Months 19 Days 19 Hours 19 Min. 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Midland, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Michael Clise		14 MOTHER'S MAIDEN NAME Susan Winters	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16 SOCIAL SECURITY NO None	
17 INFORMANT Lena Tighe		Address Midland, Md.	
18 CAUSE OF DEATH (Enter on any cause per (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4301 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO (b) CORONARY SCLEROSIS DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 10/12/1967	
23c NAME OF CEMETERY OR CREMATORY Memorial Park		23d LOCATION (City or town) (County) (State) Frostburg, Md.	
24 FUNERAL DIRECTOR GEORGE EICHHOEN		ADDRESS Lonaconing, Md.	
25a REC'D BY REGISTRAR DATE OCT 13 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

13209

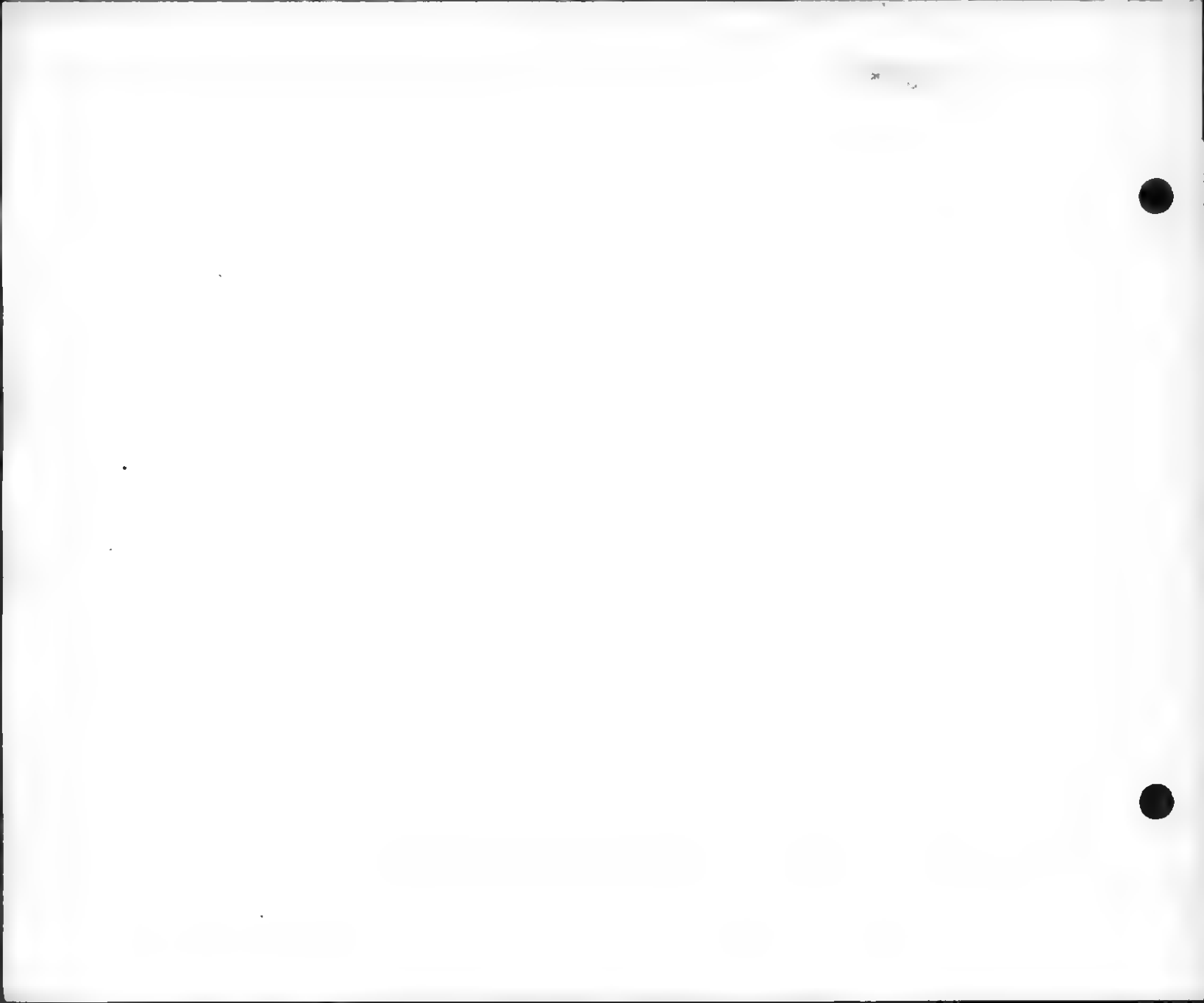
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13211

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived) First full on Residence before admission a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTOWN		c LENGTH OF STAY IN YEARS YEARS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA SACRED HEART HOSPITAL		d STREET ADDRESS CRESAP PARK	
3 NAME OF DECEASED (Type or print) First Middle Last WALLACE M. McKEE		4 DATE OF DEATH Month Day Year OCT. 15 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH AUG. 16, 1884
9 AGE (In years last birthday) yrs 83		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE FITTER		10b KIND OF BUSINESS OR INDUSTRY RAYON INDUSTRY	
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME HENRY McKEE		14 MOTHER'S MAIDEN NAME CHARLOTTE McKENZIE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 414 07 2958	
17 INFORMANT MARY TWIGG		Address CRESAPTOWN, MD.	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CORONARY SCLEROSIS DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH MINUTES ---
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. pm 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 15, 1967 Address (Street, city, town, or county) Cumberland, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF OCT. 18, 1967	23c NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK	23d LOCATION (City or town) (County) (State) FROSTBURG ALLEGANY MD.
24 FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	25a REC'D BY REGISTRAR DATE OCT 17 1967
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

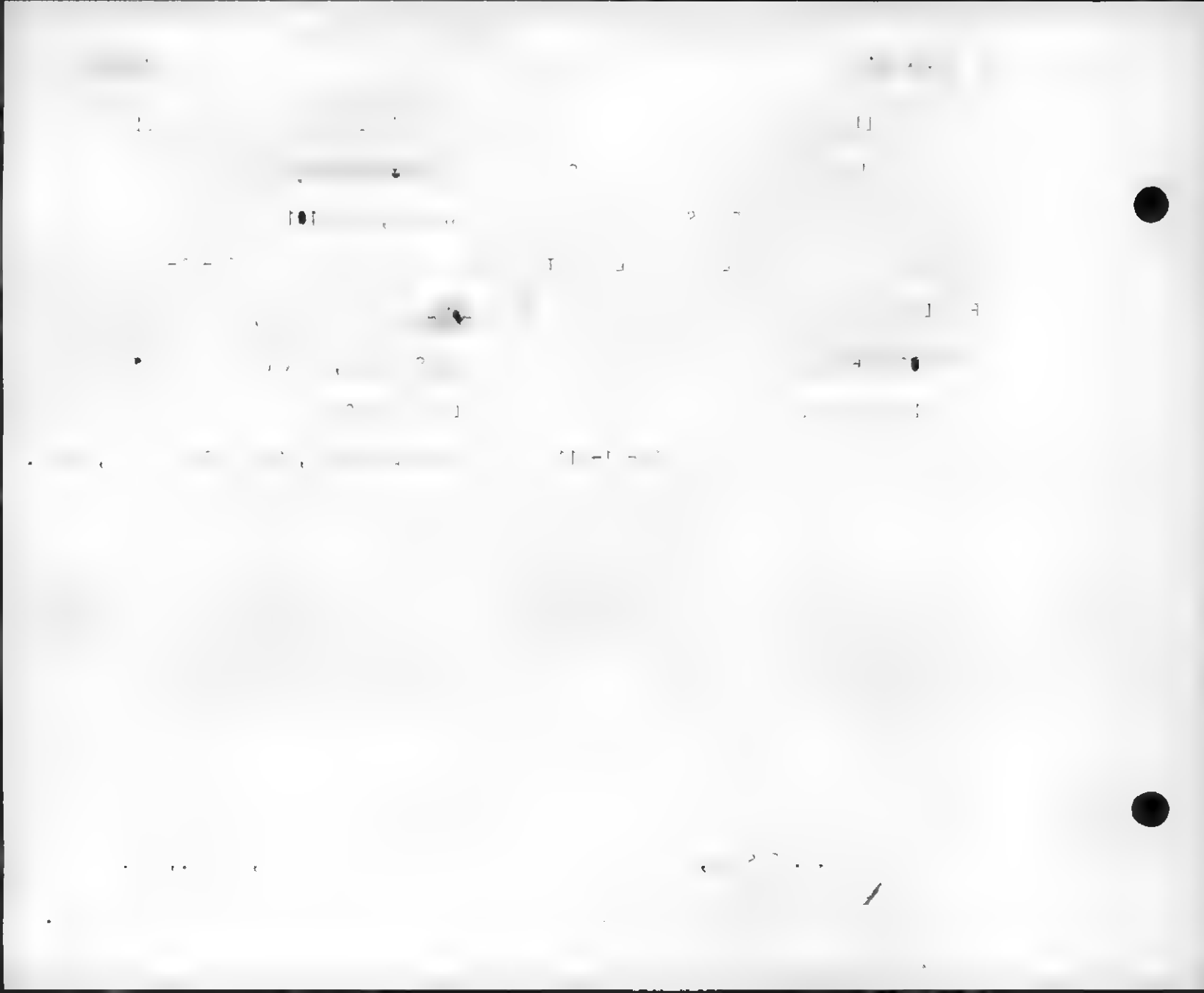
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13210 Item #3 Film #G394 11/13/67 ph

CERTIFICATE OF DEATH

-13212

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS RFD #6, BOX##01 Cumberland	
3 NAME OF DECEASED (Type or print) First NELLIE Middle ELIZABETH Last McKENZIE		4 DATE OF DEATH Month 10 Day 31 Year 67	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/8/20 5/8/20
9 AGE (in years last birthday) 47 yrs		10. USUAL OCCUPATION (Give kind of work done during last week or if retired) Domestic	
10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (County & State, or foreign country) CRESAPTOWN, MARYLAND	
13. FATHER'S NAME ALBERT MC KENIZE		14. MOTHER'S MAIDEN NAME ALICE ROBISON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 820-01-4113	
17. INFORMANT HOSPITAL RECORD, 200 SETON DRIVE, CUMB.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral hemorrhage DUE TO (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/28 , 19 67 , to 10/31 , 19 67 , that (I) (we) last saw the deceased alive on 31 Oct 19 67 , and that death occurred at 7:30 PM , from causes on and on the date stated above.			
22a SIGNATURE S. G. WEISMAN		22b DATE SIGNED 11/1/67	
22c PHYSICIAN'S NAME (Type) S. G. WEISMAN, MD		22d ADDRESS 59 GREENE STREET, CUMB., MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/3/67	23c NAME OF CEMETERY OR CREMATORY St. Ambrose Cemetery	23d LOCATION (City or Town) (County) (State) Cresaptown, Allegany Md.
24 FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		25a REC'D BY REGISTRAR NOV 6 1967	
25b REGISTRAR'S SIGNATURE J. Charles Judge			



13211

CERTIFICATE OF DEATH

13213

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN	
c. LENGTH OF STAY IN b. 27 DAYS		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROY a1 Middle CLAY Last MENGES		4. DATE OF DEATH Month OCTOBER Day 14 Year 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-13-1885
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR IND. STRY BOYD	
11. BIRTHPLACE (County & State, or foreign country) HYNDMAN, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES D. MENGES		14. MOTHER'S MAIDEN NAME Rebecca R. BEAL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-09-2546	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis DUE TO (b) Adenocarcinoma of rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 weeks post operative		INTERVAL BETWEEN ONSET AND DEATH 1 week 8 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 17, 1967 to Oct 14, 1967 that (I) (we) lost saw the deceased alive on 19 and that death occurred at 10:05 P.M. from causes and on the date stated above.		22a. SIGNATURE Fred W. Miltenberger	
22c. PHYSICIAN'S NAME (Type) DR. FRED W. MILTENBERGER		22b. DATE SIGNED OCT 20 1967	
23a. BURIAL, CREMATION, REMOVAL, etc. Burial	23b. DATE THEREOF Oct. 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery	23d. LOCATION (City or Town) (County) (State) Hyndman, Bedford Co. Pa.
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Penna.		25a. REC'D BY REGISTRAR OCT 20 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Zeigler			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

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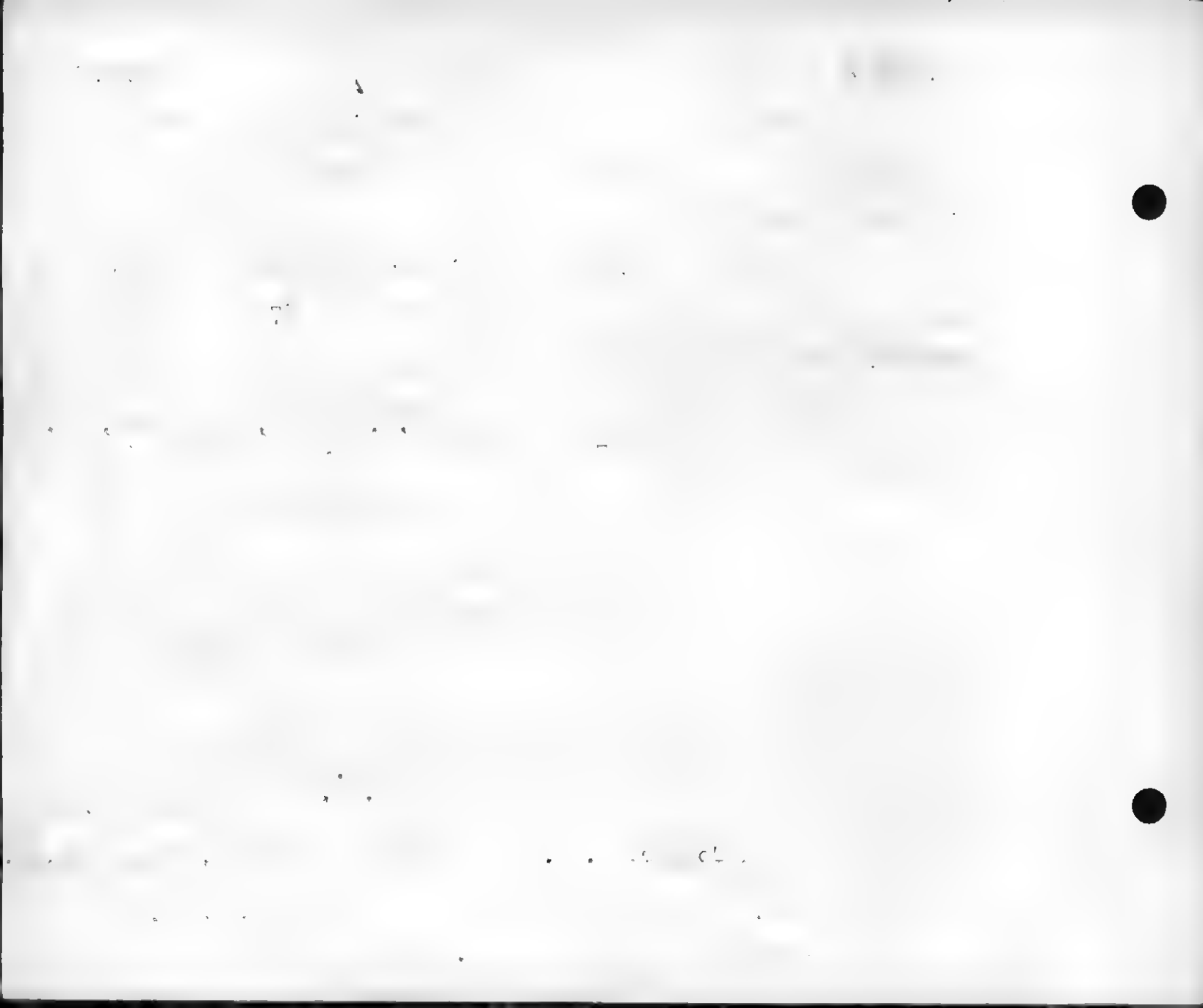
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #11 & 12 Film #3393 13/13/67 ph

13212

CERTIFICATE OF DEATH

13214

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 12/7/63			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary				d. STREET ADDRESS Oldtown			
3. NAME OF DECEASED (Type or print) First James Middle Walter Last Miller				4. DATE OF DEATH Month October Day 3 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/31/1880		9. AGE (In years last birthday) 87 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, if retired, give if retired) Retired! Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Berkley Spring, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jefferson Miller				14. MOTHER'S MAIDEN NAME Sarah McDonald			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 232-26-3221		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Arterial Sclerosis DUE TO (b) Chv. A.S.H.D. DUE TO (c) arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 1 yr. many years many years	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility with cerebral deterioration						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/7/63 , 19 63 , to 10/3/67 , 19 67 , that (I) (we) lost saw the deceased alive on 9/30/67 , 19 67 , and that death occurred at A. M. from causes on and on the date stated above.							
22a. SIGNATURE John A. Topper				at 5:00 A. M. D.S.T. M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/3/1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M. D.				22d. ADDRESS Memorial Hospital, Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 5, 1967		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Bethel, W. Va.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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VR A15 14
20 M 1/66

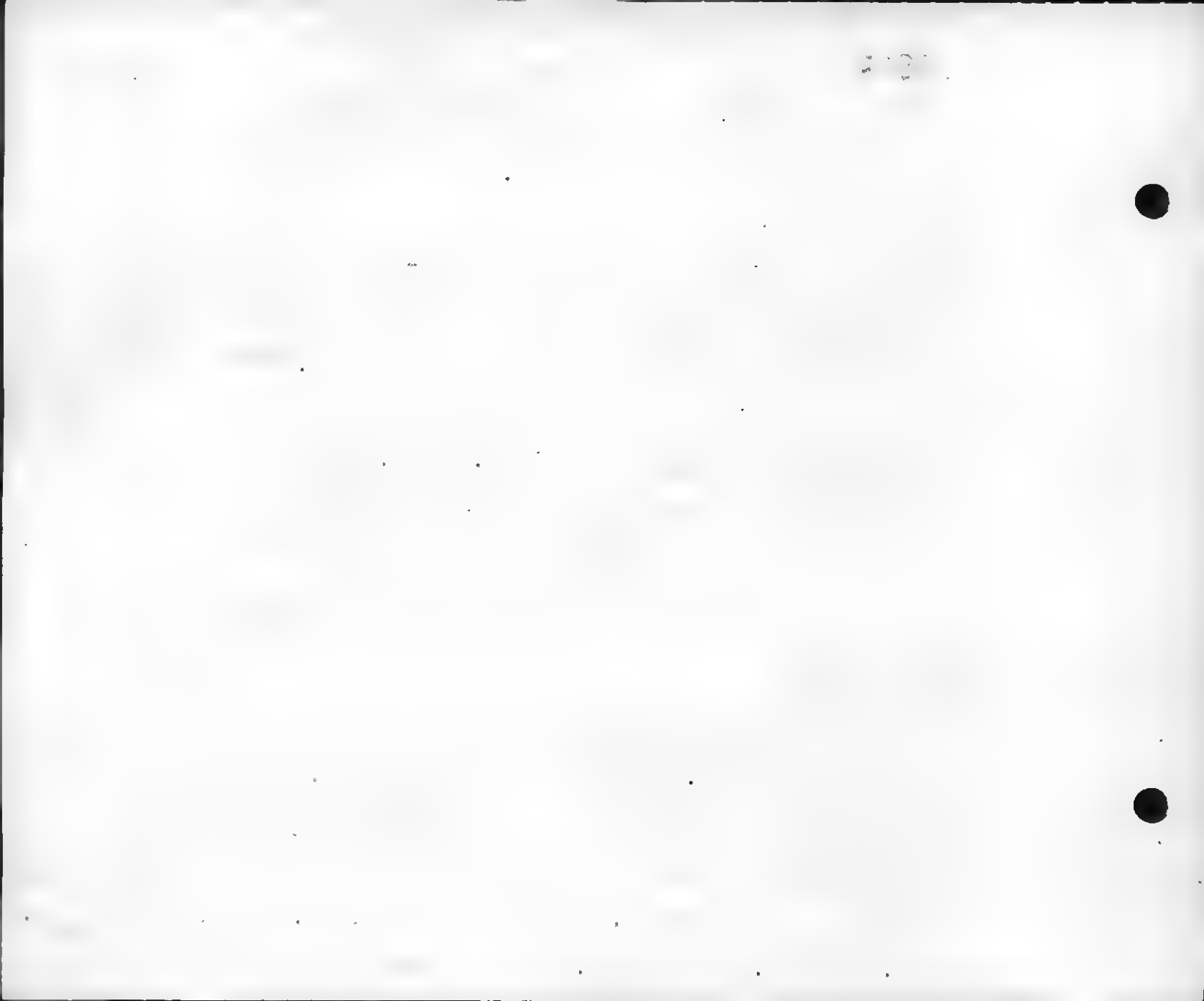
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13213

CERTIFICATE OF DEATH

13215

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in ib 4 yrs., 6 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS 109 Maple Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SYLVAN RETREAT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Pearl Last Minnick		4. DATE OF DEATH Month October Day 31 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/90
9. AGE (In years last birthday) 77 yrs		F. UNDER 1 YEAR Months 11 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Maryland (*****age)		12. CITIZEN OF WHAT COUNTRY? U S A U.S.A.	
13. FATHER'S NAME Walter Witt		14. MOTHER'S MAIDEN NAME Mary Shaffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-0065-D	
17. INFORMANT Mrs. Mary J. Buckalew, 109 Maple St		Address Frostburg Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Chc. a.s.h.d. with Hypertension DUE TO arterio-sclerosis (c) many years		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) Diagnosis of L. leg. Senile cerebral degenerative disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 15, 19 67 , to Oct. 31, 1967 , that (I) (we) last saw the deceased alive on Oct. 31 19 67 , and that death occurred at 8 P.M. from causes and on the date stated above.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED 11-1-67	
22c. PHYSICIAN'S NAME (Type) John A. Topper		22d. ADDRESS Chambers Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/3/1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Savage Methodist Cem		23d. LOCATION (City or Town) (County) (State) Mt. Savage, Alleg Md.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR NOV 6 1967	
25b. REGISTRAR'S SIGNATURE John J. Hafer, Jr.			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13214

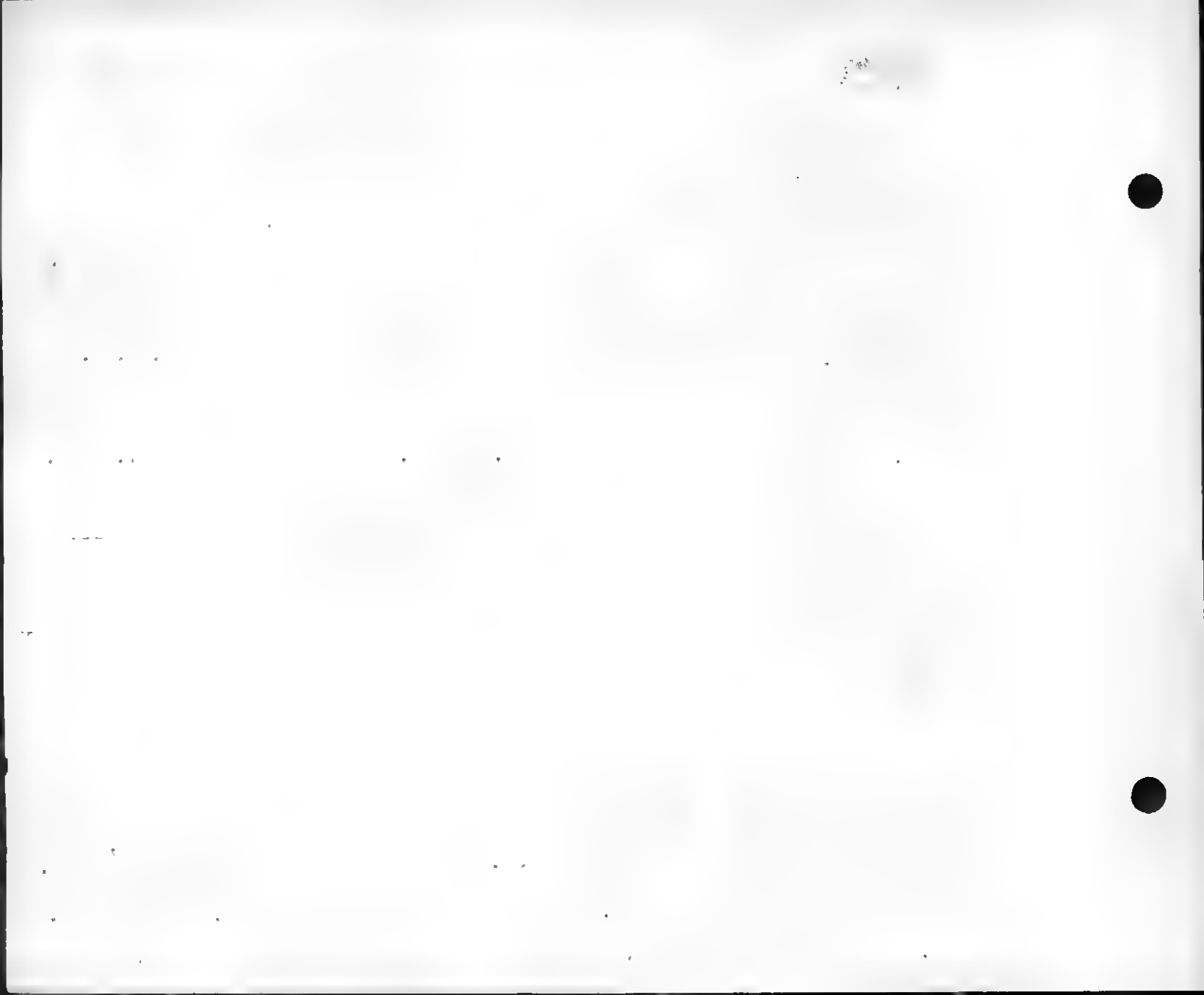
13216

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital (24 Minutes)</u>		d. STREET ADDRESS <u>115 Harrison St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine -- Moore</u>		4. DATE OF DEATH Month Day Year <u>October 20, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1887</u>
9. AGE (in years last birthday) yrs <u>86</u>		10. F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife,</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Oldtown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
3. FATHER'S NAME <u>Christopher Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Julia Ann Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No,</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mr. John R. Kelly</u>		Address <u>727 Maryland Ave. Cumb. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> -----	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>October 20, 1967</u> Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegheny Md.</u>
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 26 1967</u>	
ADDRESS <u>Cumberland, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item #8 Film #G354 11/1/57 pn

13215

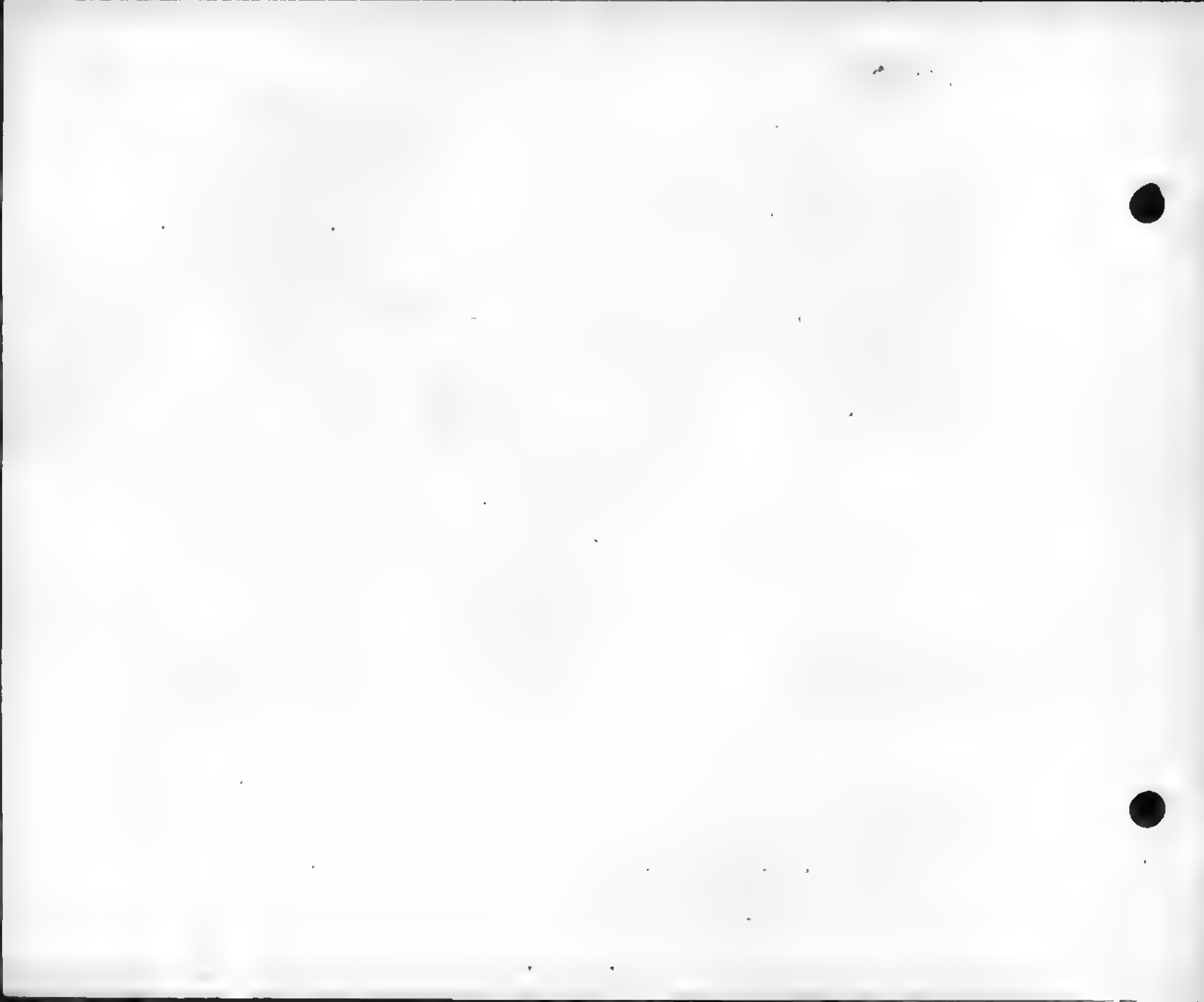
CERTIFICATE OF DEATH

13217

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1WK. 3DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 646 N. MECHANIC ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First JESSE Middle J. Last MOORE			4 DATE OF DEATH Month OCTOBER Day 26 Year 1967		
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-28-1884	9 AGE (In years, last day) 83 yrs.	IF UNOER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> M.in.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Brewery Worker		11 BIRTHPLACE (County & State, or foreign country) MARYLAND, Lonaconing	
12 CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Ezekiel J. Moore		
14. MOTHER'S MAIDEN NAME Emily Hazenbaker			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16 SOCIAL SECURITY NO. 219-03-8054		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Defendant Appending with Pen to the 550.1 DUE TO gunshot a-tumble with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) gunshot (c) gunshot					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan. 1960 to Oct 26, 1967 , that (I) (we) last saw the deceased alive on Oct 25, 1967 , and that death occurred at 3:30 AM, Aom Maus and on the date stated above.			
22a. SIGNATURE DR. B. SCHINDLER			22b. DATE SIGNED 10/27/67		
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER			22d. ADDRESS CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-28-67		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	
23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland		24. FUNERAL DIRECTOR ADDRESS H. Lee Silcox 404 Decatur St., Cumb., Md.			
25a. REC'D BY REGISTRAR OCT 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The **death certificate** requires that the **death certificate** be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove subpage papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13216 CERTIFICATE OF DEATH 13218											
1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>W. Va.</i> b. COUNTY <i>Mineral</i> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>				c. LENGTH OF STAY IN lb <i>12 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rt. # 2 Keyser, W. Va.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hosp.</i>						d. STREET ADDRESS <i>Short Gap,</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Joy</i> Middle <i>Elaine</i> Last <i>Moreland</i>			4. DATE OF DEATH Month <i>October</i> Day <i>8</i> Year <i>1967</i>								
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 9, 1949</i>		9. AGE (In years last birthday) <i>18</i> yrs.		IF UNDER 1 YEAR: Months <i></i> Days <i></i> Hours <i></i> Min. <i></i> IF UNDER 24 HRS. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Cumberland, Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Arthur C. Moreland</i>						14. MOTHER'S MAIDEN NAME <i>Irene M. Blauch</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Mr. Arthur C. Moreland Rt. # 2 Keyser, W. Va.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i> DUE TO (b) <i>CHRONIC GLOMERULONEPHRITIS</i> DUE TO (c) <i>VON GIERKE'S DISEASE---TYPE I</i>										INTERVAL BETWEEN ONSET AND DEATH <i>MONTHS</i> <i>YEARS</i> <i>BIRTH</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>ARTERIOSCLEROSIS</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <i></i> a.m. <i></i> p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1954</i> , to <i>PRESENT, 1967</i> , that (I) (we) last saw the deceased alive on <i>OCT 8 1967</i> , and that death occurred at <i>7:00 P.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>G.O. Himmelwright</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>10-11-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>G.O. HIMMELWRIGHT, MD</i>						22d. ADDRESS <i>133 VIRGINIA AVE. CUMBERLAND, MD</i>					
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10/11/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Levels Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Levels, Hampshire, W. Va.</i>			
24. FUNERAL DIRECTOR <i>H. Wayne George Cumberland, Maryland</i>						25a. REC'D BY REGISTRAR <i>OCT 16 1967</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

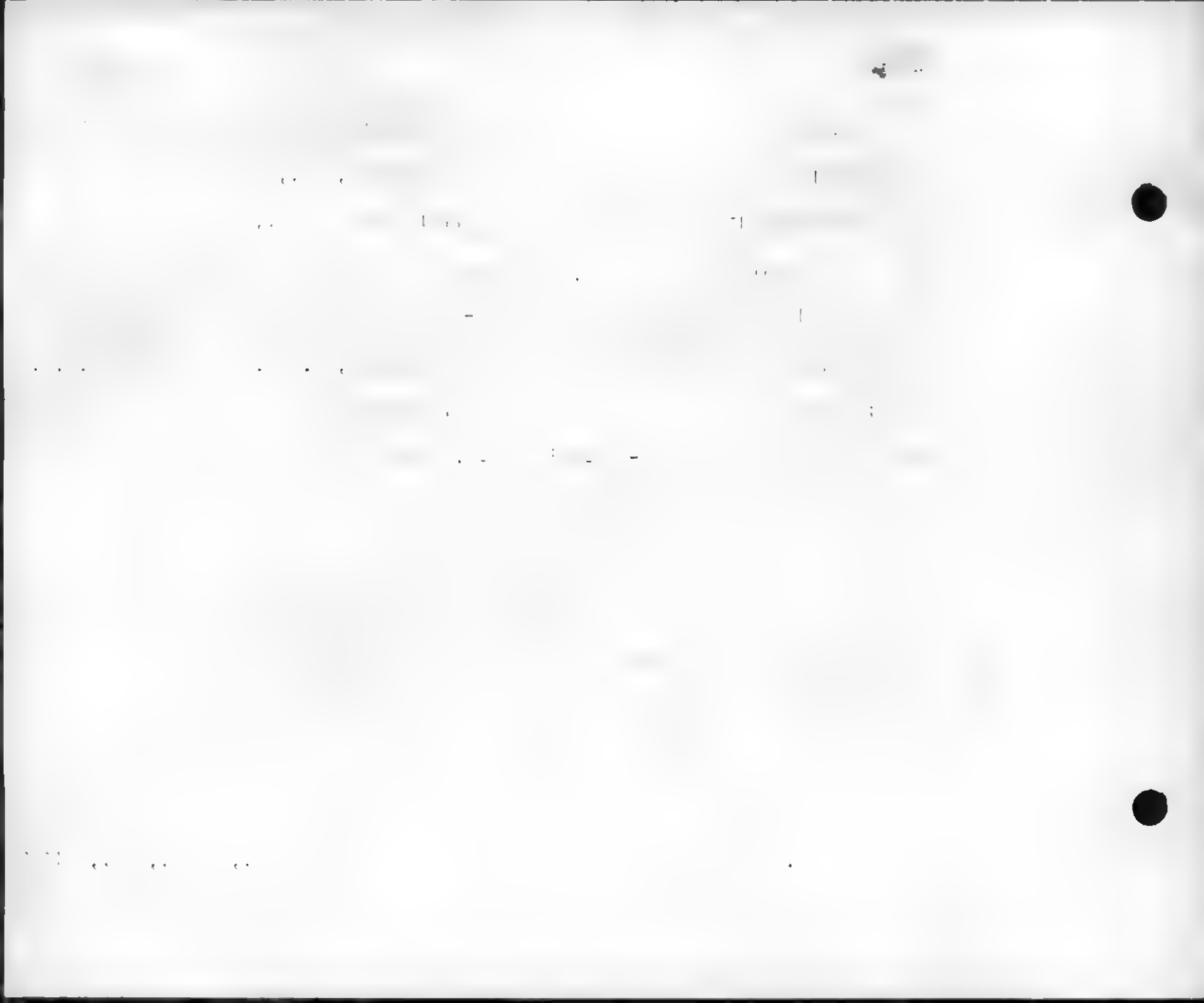
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13217

CERTIFICATE OF DEATH

13219

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 1101 BRADDOCK RD.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MYRTLE Middle S. Last NAZELROD		4 DATE OF DEATH Month OCTOBER Day 16 Year 19 67	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-2-84
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) PETERSBURG, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN ALT		14. MOTHER'S MAIDEN NAME SIPHRONE GEORGE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 217-54-6511	
17. INFORMANT HOSP. RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4x cerebral stroke DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-14- , 19 67 , to 10-16- , 19 67 , that (I) (we) last saw the deceased alive on 10-15- 19 67 , and that death occurred at 10-16- M, from causes and on the date stated above			
22a. SIGNATURE L. Brings		22b. DATE SIGNED 10-16-67	
22c. PHYSICIAN'S NAME (Type) DR. LEWIS BRINGS		22d. ADDRESS 57 GREENE ST., CUMB., MD., 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 19, 1967	
23c. NAME OF CEMETERY OR CREMATORY Nazelrod Cemetery		23d. LOCATION (City or town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR William G. Kight		25a. REC'D BY REGISTRAR OCT 23 1967	
25b. REGISTRAR'S SIGNATURE John J. Jones			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13218

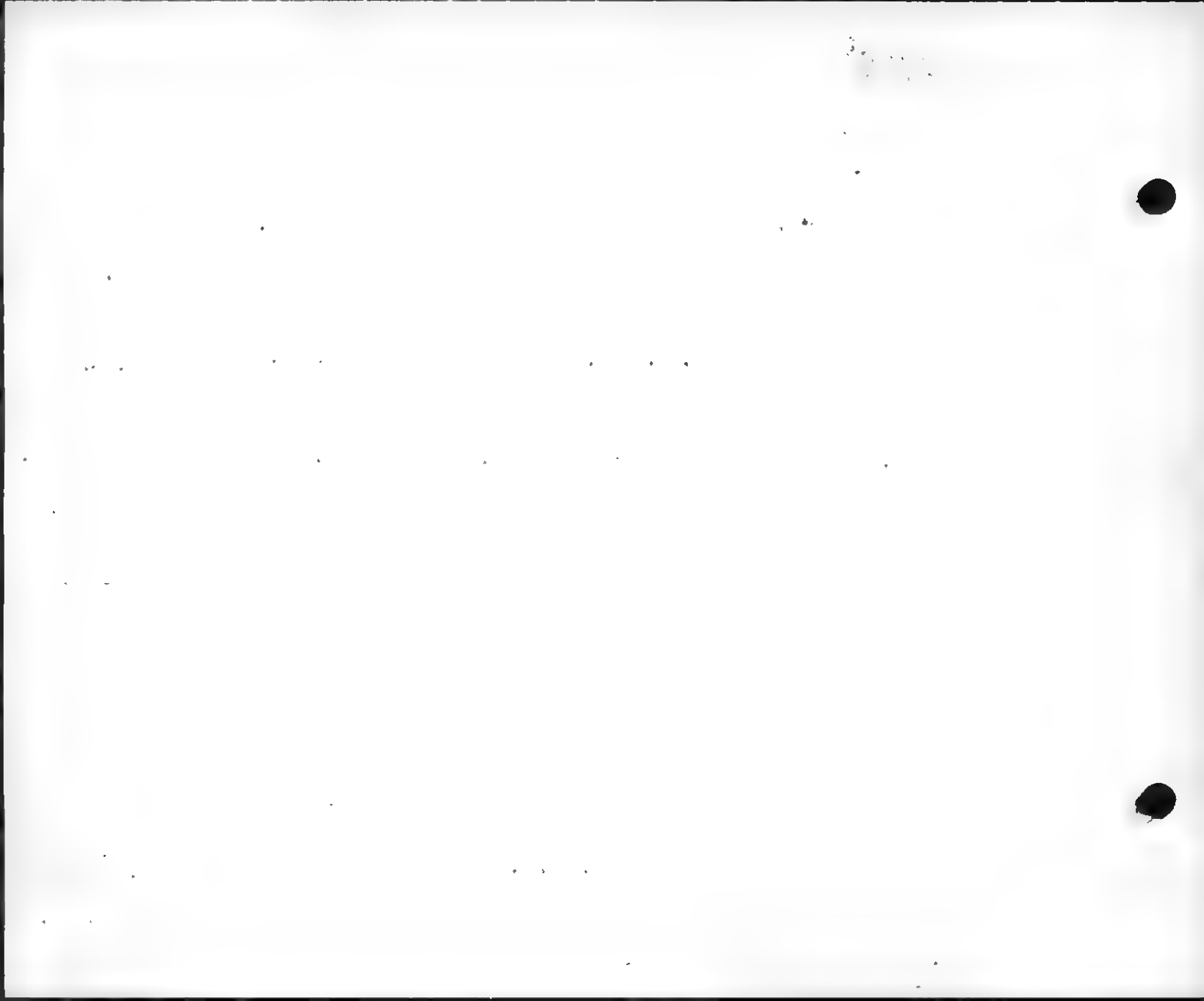
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13220

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PW3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Allegany</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Allegany</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>			c LENGTH OF STAY IN 1b <u>5 days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>				d STREET ADDRESS <u>744 Maryland Ave.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Shepherd</u> Last <u>Neff</u>				4 DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>1967</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>April 19, 1895</u>	
9 AGE (In years last birthday) <u>72</u> yrs		10a USUA. OCCUPATION (Give kind of work done during part of working life, even if retired) <u>machinist</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Rail.</u>		11 BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13 FATHER'S NAME <u>George R. Neff</u>			
14 MOTHER'S MAIDEN NAME <u>Sallie Bickford</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16 SOCIAL SECURITY NO <u>705-09-9862</u>				17 INFORMANT Address <u>Mrs. Ruth Neff 744 Maryland Ave. Cumb. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular Disease--</u> DUE TO (c) <u>----</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>October 24, 1967</u> Address (Street, city, town, or county) <u>Cumberland, Maryland</u>			
22. DATE SIGNED							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>10/26/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Hollcrest Burial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany, Md.</u>	
24 FUNERAL DIRECTOR <u>H. Wayne George Cumberland, Md.</u>				25a. REC'D BY REG. STRAR <u>OCT 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

13218

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13221

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 44 WRIGHT STREET	
3. NAME OF DECEASED (Type or print) First AGATHA Middle NMI Last NICOLATO		4. DATE OF DEATH Month 10 Day 16 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-10-90
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME JEROME BIASI		14. MOTHER'S MAIDEN NAME DOMINICA ARSEGO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-24-8365A	
17. INFORMANT HOSPITAL RECORD, 200 SETON DRIVE, CUMB., MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 73300 DUE TO Congestive heart failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atrial fibrillation (c) arteriosclerotic Cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Clarence T. Vincent		22b. DATE SIGNED 10/17/67	
22c. PHYSICIAN'S NAME (Type) CLARENCE VINCENT, M.D.		22d. ADDRESS 126 N. SMALLWOOD ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-19-67	23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR 21532	25b. REGISTRAR'S SIGNATURE Charles Judge

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the (Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

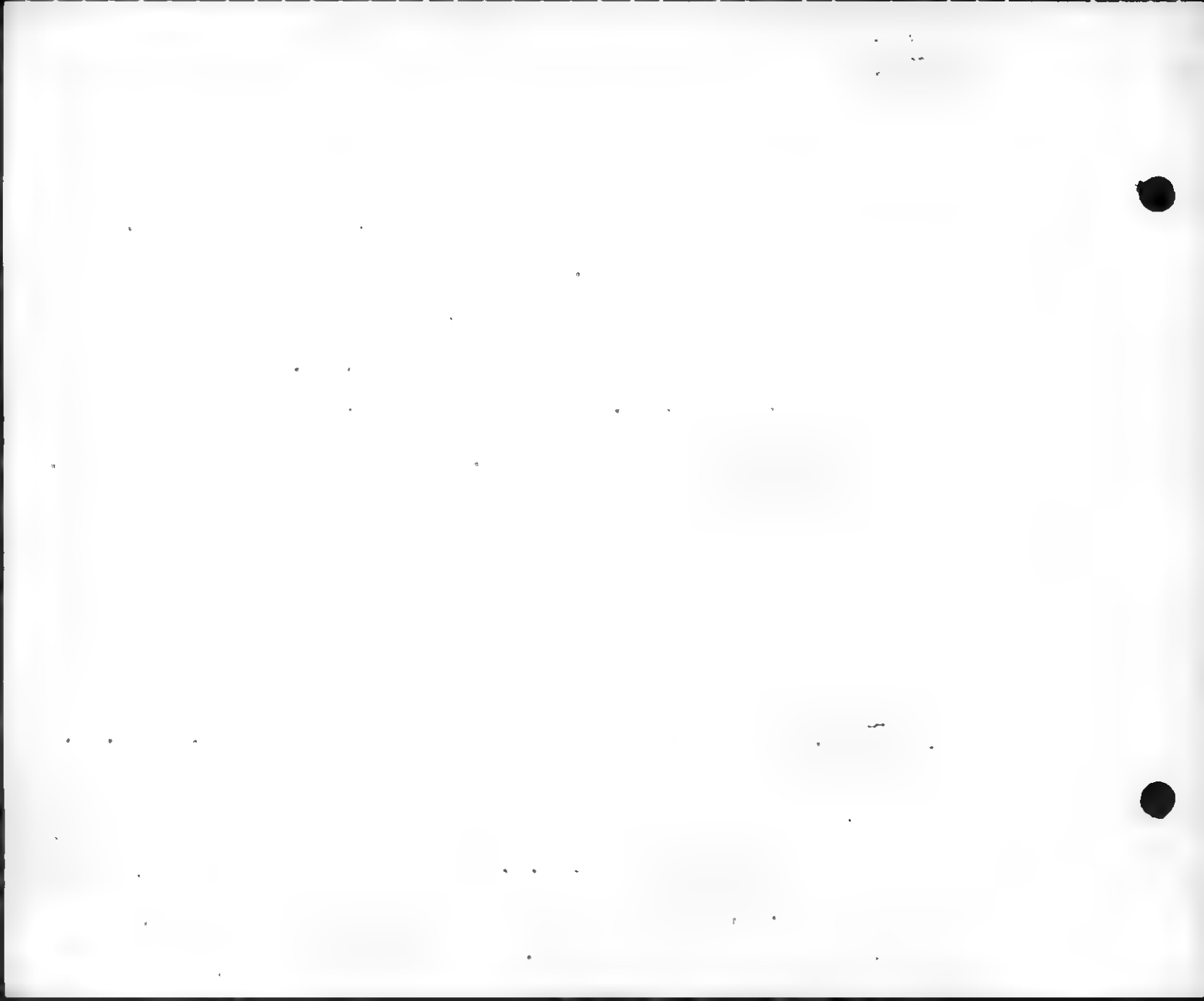
13220

Item #9 Film #3396 12/30/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13222

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital (1 hour)			d. STREET ADDRESS York Hotel, 202 Baltimore Ave.		
3 NAME OF DECEASED (Type or print) First Middle Last Guy D. O'Hara, Jr.			4 DATE OF DEATH Month Day Year Oct. 23 19 67		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH Aug. 16, 1921	9 AGE (In years last birthday) 47 46 yrs	IF UNDER 1 YEAR Months Days Hours Min 47 46
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worker		10b. KIND OF BUSINESS OR INDUSTRY Cleaning Estab.		11 BIRTHPLACE (State or foreign country) Gladys, W. Va.	
13 FATHER'S NAME Guy D. O'Hara, Sr.			14. MOTHER'S MAIDEN NAME Nell Clarke		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes War II		16. SOCIAL SECURITY NO		17 INFORMANT Address Sister Mrs. Pauline Holihan, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Skull Fracture DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Fall from third story) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell from third story window			
20c. TIME OF INJURY Month, Day, Year 11:45 p.m. Oct. 23 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Cumberland, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED October 24, 1967 Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 26, 1967	23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City or town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			25a. REC'D BY REGISTRAR DATE OCT 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

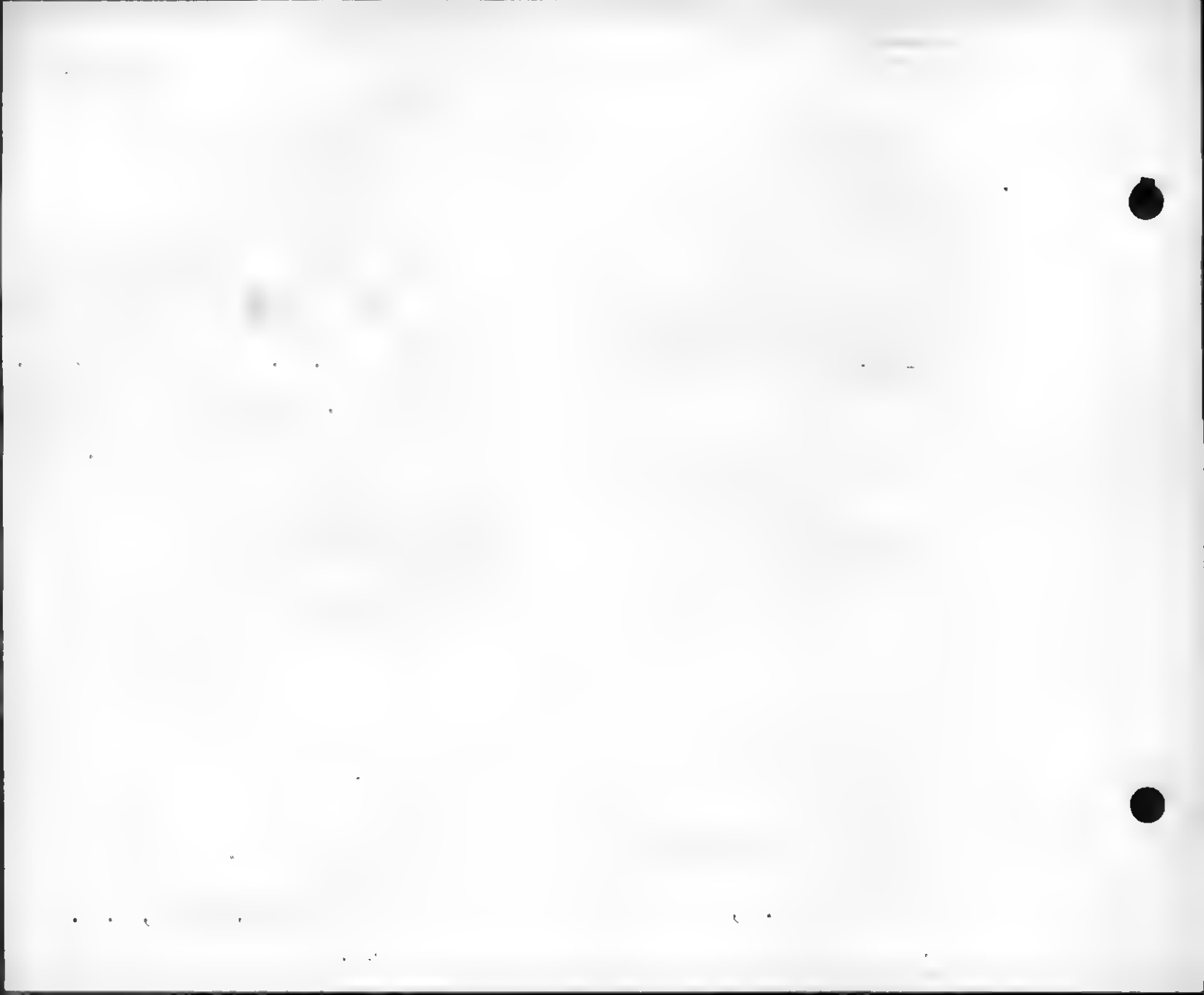


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="display: flex; justify-content: space-between;"> 13221 MARYLAND STATE DEPARTMENT OF HEALTH 13223 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 24 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						d. STREET ADDRESS RT. 1, BOX 448				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle Blaine Last PARSONS						4. DATE OF DEATH Month OCTOBER Day 30 Year 1967					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-19-05		9. AGE years 62 days 12 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (County & State, or foreign country) PARSONS, W.VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT PARSONS						14. MOTHER'S MAIDEN NAME BERTIE C. JOHNSON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO 232-10-9738		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary artery disease 4201 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO Arteriosclerosis with decompensation (c) Arteriosclerosis with decompensation										INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1958 to Oct 30, 1967 that (I) (we) last saw the deceased alive on Oct 30, 1967 and that death occurred on Oct 30, 1967 at 1:50 AM , from causes on and the date stated above.											
22a. SIGNATURE B. Blane Schindler						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Oct 30/67			
22c. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER						22d. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 2, 1967		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Parsons, Tucker, W. Va.					
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.						25a. REC'D BY REGISTRAR DATE NOV 7 1967		25b. REGISTRAR'S SIGNATURE [Signature]			



13222

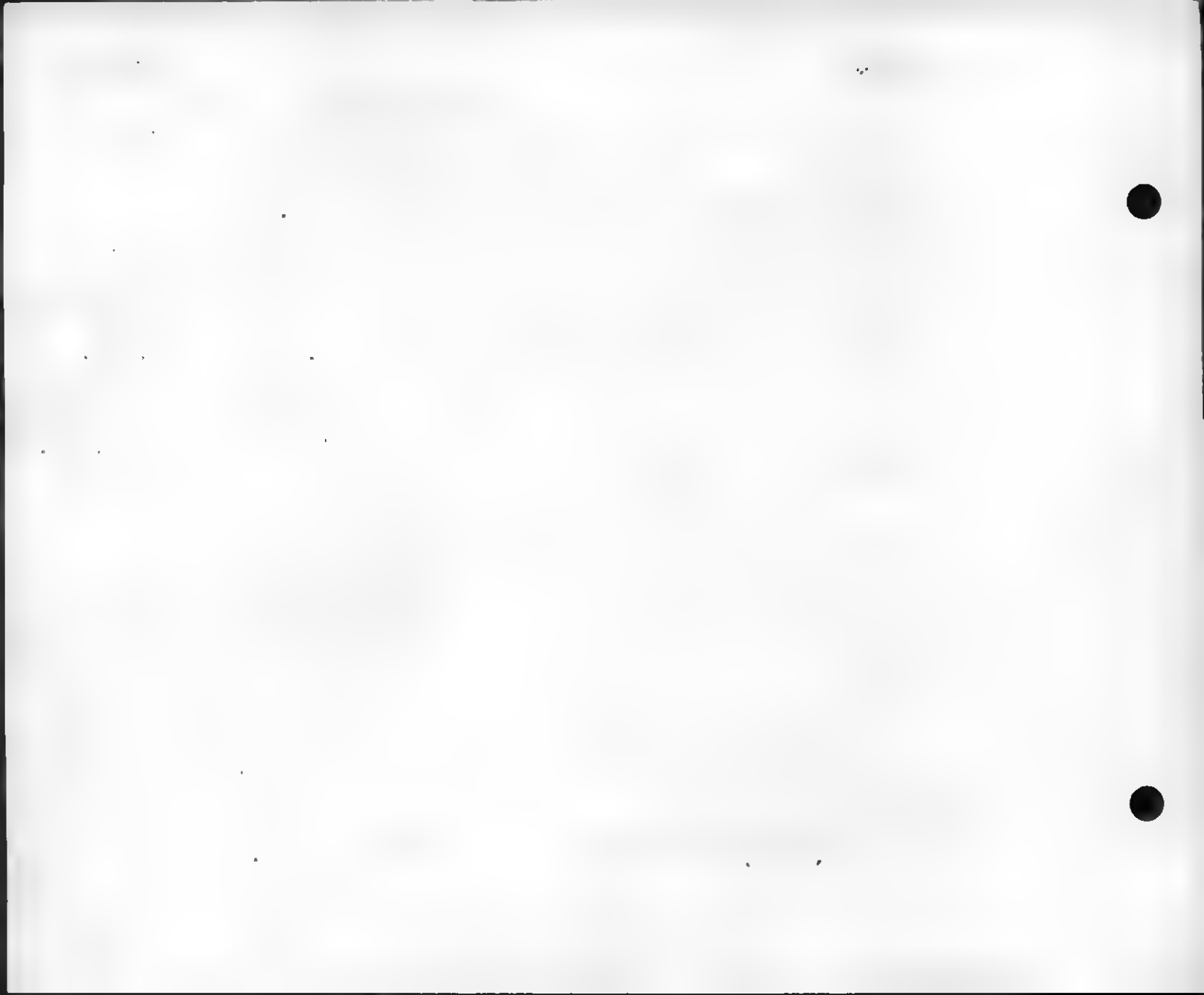
CERTIFICATE OF DEATH

13224

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b. 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 151 HILL ST.	
3. NAME OF DECEASED (Type or print) First EVELYN Middle M Last PLUMMER		4. DATE OF DEATH Month OCTOBER Day 19 Year 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-5 10
9. AGE (In years last birthday) 57 yrs		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) ECKHART, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM PAPE		14. MOTHER'S MAIDEN NAME MARY E. HOLSINGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N.A.		16. SOCIAL SECURITY NO. 220-52-9736	
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 6 yrs 4 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)	20f. (City or town) Cumby, Allegany (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from 4/7/61 , 19____, to 9/10/67 , 19____, that (I) (we) last saw the deceased alive on 10/17/67 , 19____, and that death occurred at 9:40 P.M. , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 10/21/67	
22c. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS, M.D.		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 22, 1967	23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY	23d. LOCATION (City or Town) ECKHART (County) MARYLAND (State)
24. FUNERAL DIRECTOR MARILYN M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG		25a. REC'D BY REGISTRAR DATE OCT 24 1967	
25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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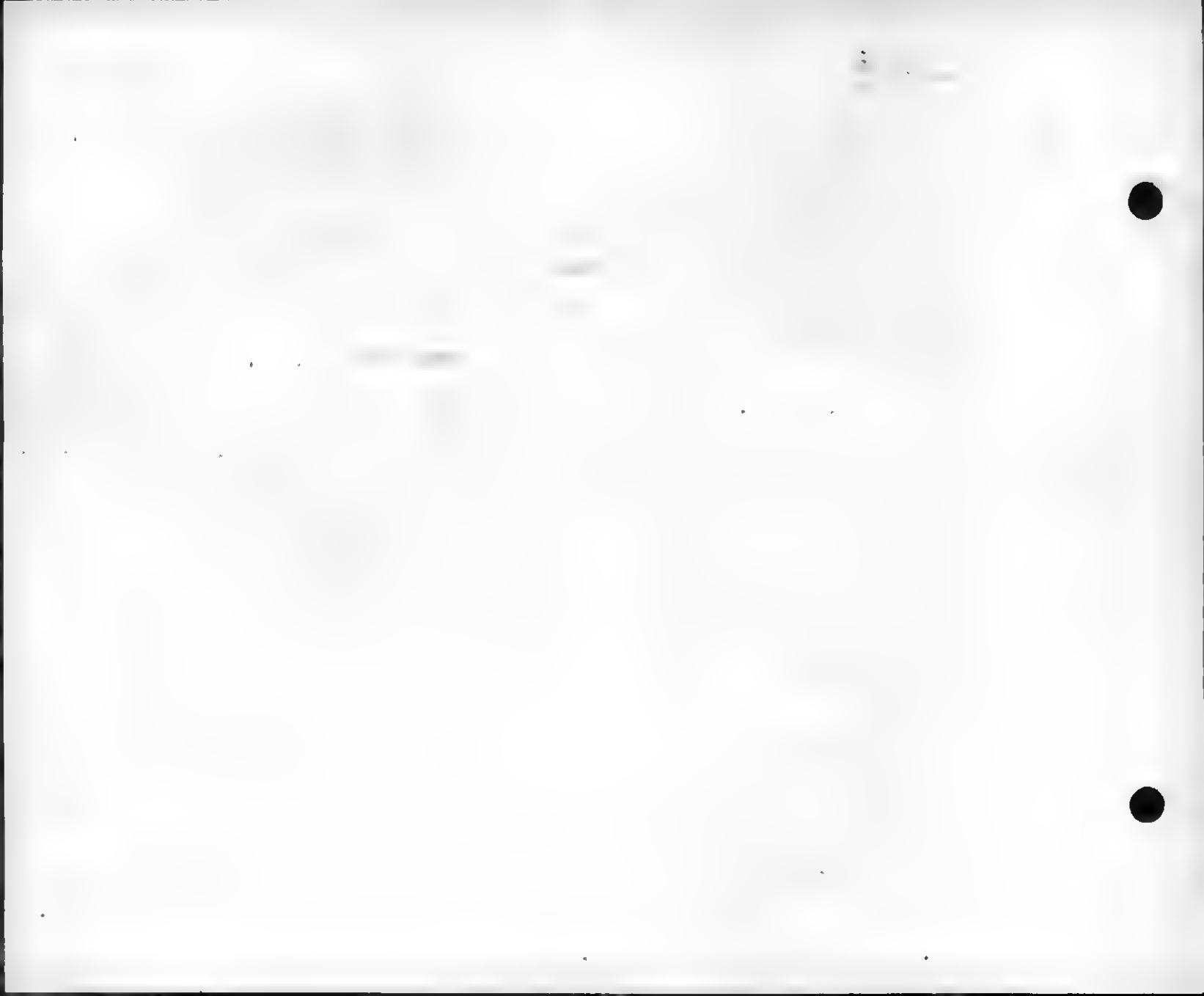
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13222

CERTIFICATE OF DEATH

13225

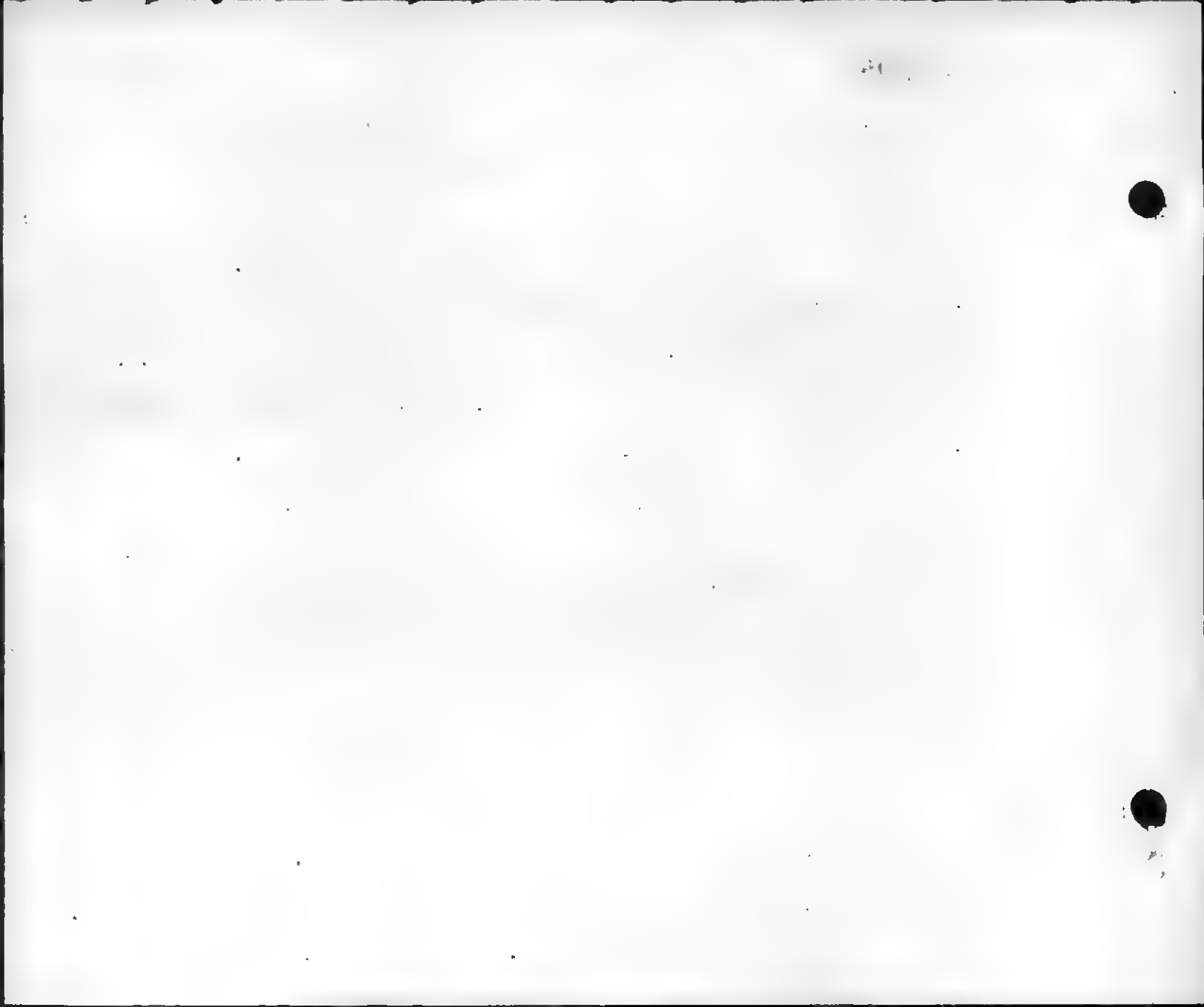
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 1/2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 101 GREENE STREET	
3. NAME OF DECEASED (Type or print) EUGENIA Hottense		4. DATE OF DEATH OCTOBER 8, 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-1876
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Own home	
11c. BIRTHPLACE (County & State, or foreign country) Greenspring, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN P. Ullman		14. MOTHER'S MAIDEN NAME SUSAN WARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO Generalized Atherosclerosis (b) Myocardial Infarction DUE TO Coronary Artery Disease (c) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 1-2-2-10-22	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Cumberland, Allegany, Md.
21. I certify that (I) (this hospital) attended the deceased from 10/7/67 , 19 67 to 10/8/67 , 19 67 that (I) (we) last saw the deceased alive on 10/7/67 , and that death occurred at 12:45 A.M. on the date stated above.			
22a. SIGNATURE DR. R.J. WILLIAMS		22b. DATE SIGNED 10/8/67	
22c. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/11/67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S NAME [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13224 Item #9 Film #G393-10/23/67-eb											
13226											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Barton						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Barton					
c. LENGTH OF STAY IN ID 55 Yrs						d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)											
3. NAME OF DECEASED (Type or print) Ray Alton Preston						4. DATE OF DEATH Oct. 17 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1910		9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer						10b. KIND OF BUSINESS OR INDUSTRY Roofing		11. BIRTHPLACE (County & State, or foreign country) Allegany-Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Preston						14. MOTHER'S MAIDEN NAME Aney Metz					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. 417-05-0773		17. INFORMANT Alta Preston-Barton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO (b) Coronary Insufficiency DUE TO (c) Generalized Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Oct 12, 1967 to Oct 12, 1967 that (I) (we) last saw the deceased alive on Oct 16, 1967 and that death occurred at 11 PM from the causes and on the date stated above.											
22a. SIGNATURE Leslie Miles						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-18-67			
22c. PHYSICIAN'S NAME (Type) Leslie Miles						22d. ADDRESS Lonaconing, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/20/67		23c. NAME OF CEMETERY OR CREMATORY Salisbury		23d. LOCATION (City, town or county) (State) Salisbury Pa.					
24. FUNERAL DIRECTOR Westernport, Md.						25a. REC'D BY REGISTRAR OCT 20 1967		25b. REGISTRAR'S SIGNATURE			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

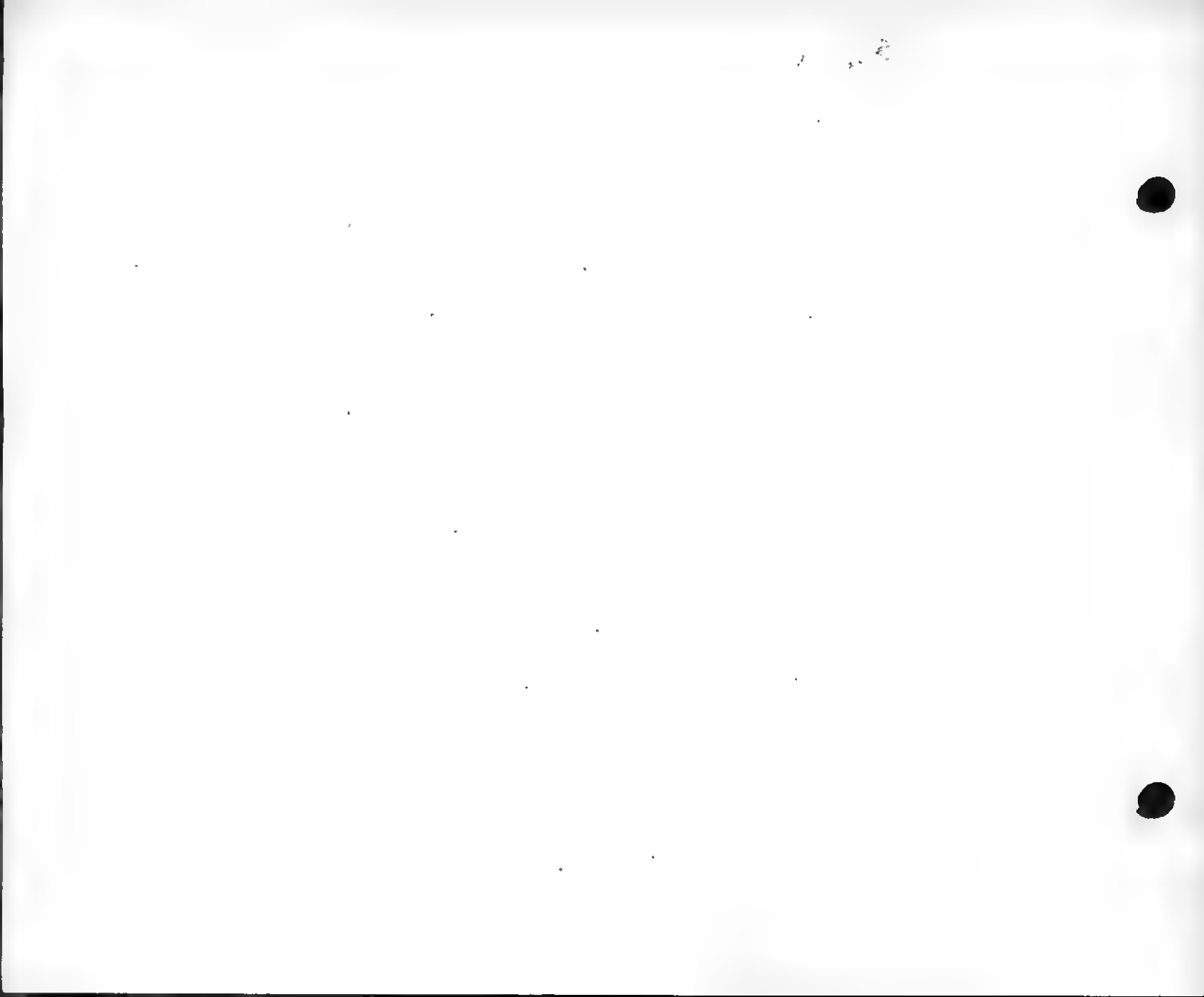
13225

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13227

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 34 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. STREET ADDRESS 117 W. MAIN ST.	
3 NAME OF DECEASED (Type or print) EMMA First Middle Last		4. DATE OF DEATH OCTOBER 10, 1967 Month Day Year	
5 SEX FEMALE		6 COLOR OR RACE WHITE	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH OCT. 1, 1882	
9 AGE (In years last birthday) 85 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME THOMAS EVANS		14 MOTHER'S MAIDEN NAME MARY A. LANGFORD	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 213-09-6485A		7 INFORMANT PERCY E. RACE, FROSTBURG, MD. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gangrene of Bowel DUE TO (b) Meenteric Thrombosis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3-4 days 3-4 days —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) Fracture of left humerus		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell at home	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Home		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 12, 1967	
23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATED ON (City or Town) (County) (State) FROSTBURG, MD.	
24 FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR DATE OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		27. DATE SIGNED OCT 10, 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13226

CERTIFICATE OF DEATH

13228

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN TB 3 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ELMER Middle MARSHALL Last ROBOSSON		4 DATE OF DEATH Month OCT. Day 8 Year 19 67.	
5. SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-1919
9 AGE (In years last birthday) yrs 47		10. UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee- Kelly Springfield Tire Co.		11b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. BIRTHPLACE (County & State, or foreign country) MARYLAND	
14. FATHER'S NAME THOMAS P. ROBOSSON		15. MOTHER'S MAIDEN NAME ANNA R. ROBINETTE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		17. SOCIAL SECURITY NO 217-10-5911	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the lung X with metastases to the brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) 9 months (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
21a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	21b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21d. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 10-5 , 19 67 , to 10-8 , 19 67 , that (I) (we) last saw the deceased alive on 10-7 , 19 67 , and that death occurred at 7:25 A.M. on 10-8 , 19 67 , and on the date stated above.			
22a. SIGNATURE Dr. I. Dross		22b. DATE SIGNED 10/9/67	
22c. PHYSICIAN'S NAME (Type) DR. I. DROSS		22d. ADDRESS 456 N. CENTRE ST. CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/11/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or town) (County) (State) Cumberland Allegany Maryland
24 FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR OCT 11 1967	
ADDRESS Cumberland, Maryland 21502		25b. REGISTRAR'S SIGNATURE [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

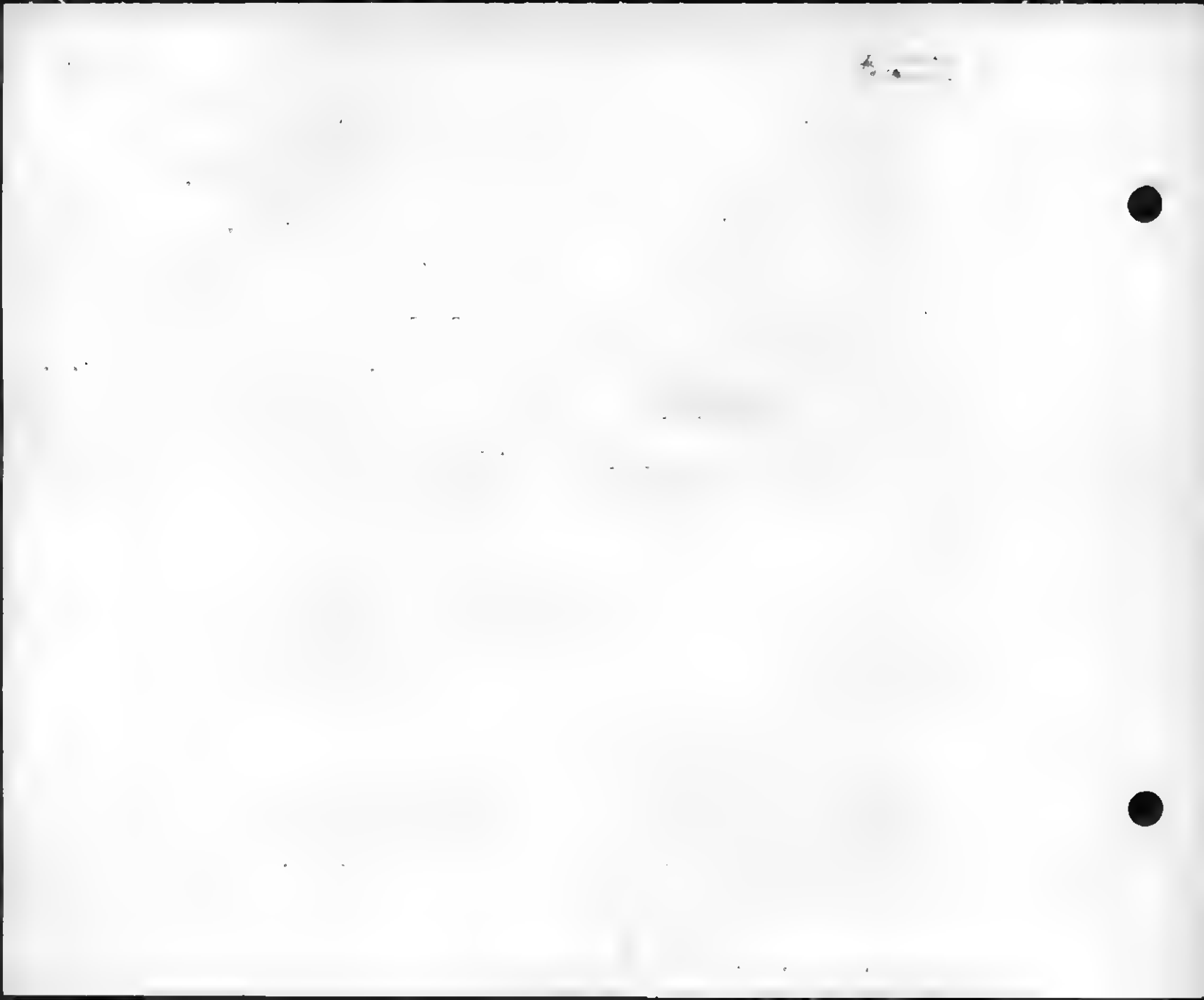
13227

CERTIFICATE OF DEATH

13229

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 30 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 102 HILLCREST RD.	
3. NAME OF DECEASED (Type or print) First ESTHER Middle C Last RUNYAN		4. DATE OF DEATH Month OCT Day 10 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-23
9. AGE (In years last birthday) 44 yrs		10. IF UNDER 1 YEAR Months Days Hours M.n.	11. IF UNDER 24 HRS Months Days Hours M.n.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) PITTS, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LIVINGSTONE CHARLES R. XXXXXXXXX		14. MOTHER'S MAIDEN NAME HOLZWORTH VIRGINIA HOLZWORTH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 2		16. SOCIAL SECURITY NO. 185-12-7412	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Liposarcoma - 1867 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary in lumbar fat - DUE TO (c) Generalized metastasis			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-10-67 , 19 to 10/10/67 , 19, that (I) (we) last saw the deceased alive on 10/10/67 , 19, and that death occurred at 1:50AM , from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Lusby		22b. DATE SIGNED 10/12/67	
22c. PHYSICIAN'S NAME (Type) DR. THOMAS F. LUSBY		22d. ADDRESS LA VALE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/13/1967	23c. NAME OF CEMETERY OR CREMATORY Winchester National Cem.	23d. LOCATION (City or Town) (County) (State) Winchester Frederick Va
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR DCT 13 1967	
25b. REGISTRAR'S SIGNATURE John J. Hafer, Jr.		25c. REGISTRAR'S SIGNATURE John J. Hafer, Jr.	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

13228

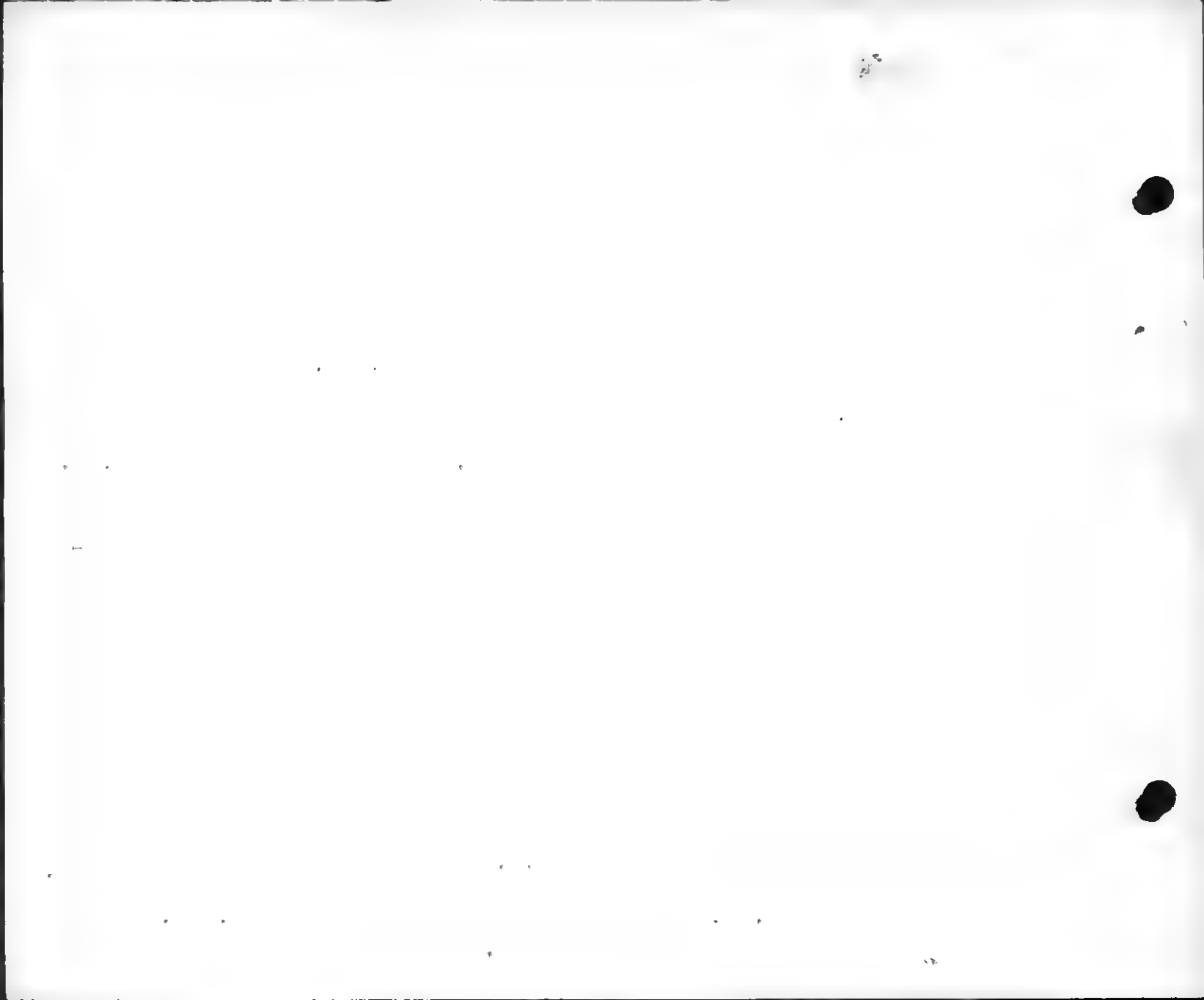
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13230

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay in necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Allegheny MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Pennsylvania b COUNTY Bedford			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN 1b DOA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyndman			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d STREET ADDRESS			
3 NAME OF DECEASED (Type or print) First Middle Last Clarence William Sarver				4 DATE OF DEATH Month Day Year October 25, 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 16, 1910	9 AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11 BIRTHPLACE (State or foreign country) Fairhope, Pa. RD#1		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Ross M. Sarver				14. MOTHER'S MAIDEN NAME Ivana Miller Sarver			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 209-09-1769		17 INFORMANT Address Mrs. Clarence Sarver, Hyndman, Pa.			
18. CAUSE OF DEATH (Enter any one cause per one for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden ----	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelis		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED October 25, 1967	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Oct. 28, 1967		23c NAME OF CEMETERY OR CREMATORY Miller Cemetery		23d LOCATION (City or Town) (County) (State) Fairhope, Pa. RD#1	
24 FUNERAL DIRECTOR Harvey J. Zeigler		ADDRESS Hyndman, Pa.		25a REC'D BY REGISTRAR DATE NOV 1 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



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VR A15 (4)
25M 1/67

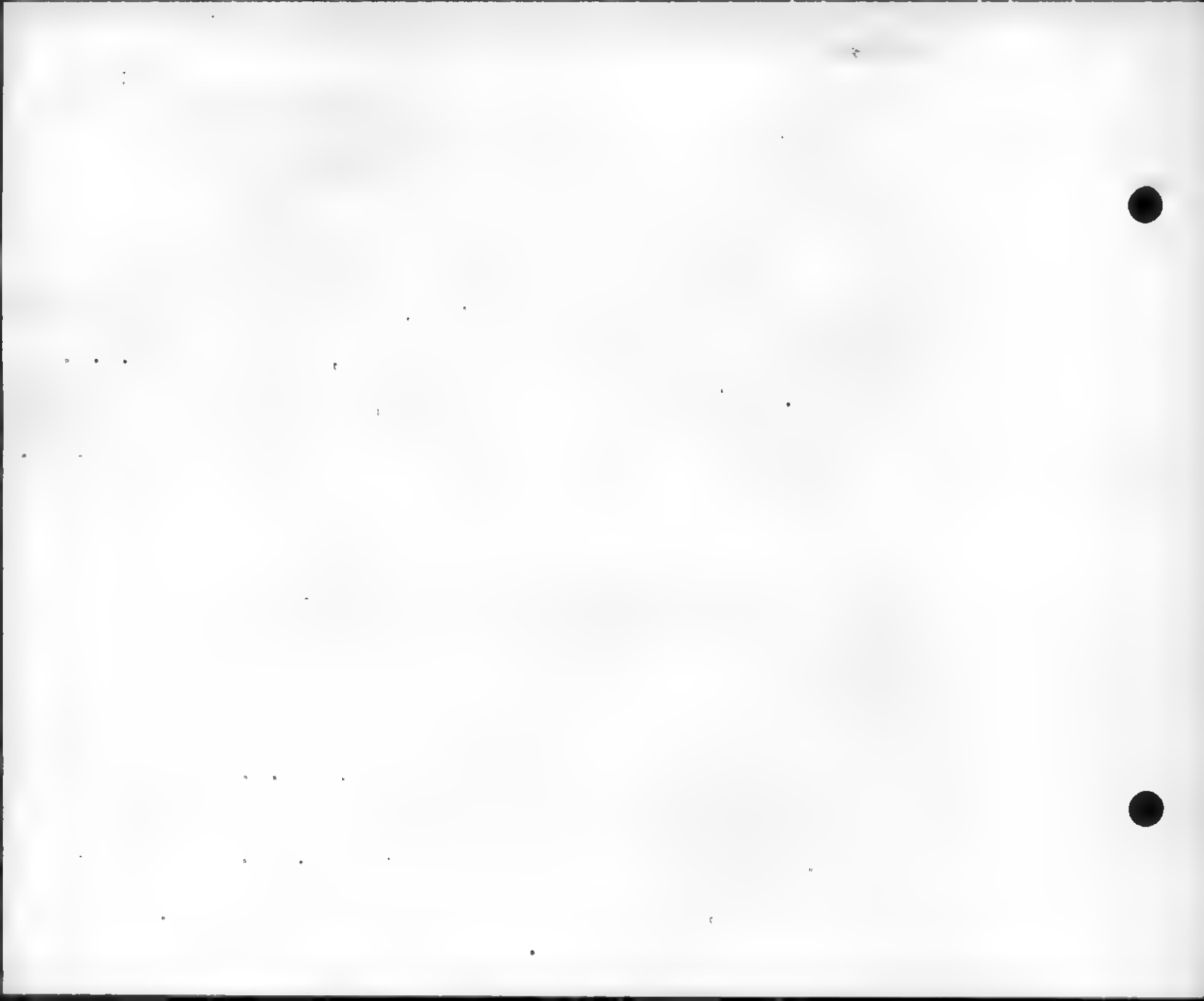
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13229

CERTIFICATE OF DEATH

13231

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 58 WEMPE DRIVE	
3 NAME OF DECEASED (Type or print) First HOMER Middle N Last SELLERS		4 DATE OF DEATH Month OCTOBER Day 18 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-31-91
9 AGE (In years last birthday) 75-76		10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Pipelitter	10b KIND OF BUSINESS OR INDUSTRY Textile
11 BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES A. SELLERS		14. MOTHER'S MAIDEN NAME KATHERINE MANDEL	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War I		16 SOCIAL SECURITY NO 217-10-5343	17 INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO (b) Carcinoma Prostate DUE TO (c) Coronary Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 15 min 4 hrs 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 18, 1967 to Oct 18, 1967 that (I) (we) last saw the deceased alive on Oct 18, 1967 , and that death occurred at 6:40 P.M. from causes and on the date stated above			
22a. SIGNATURE Clay Durrett M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 10/19/67
22c. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Oct. 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE OCT 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-2. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1 67

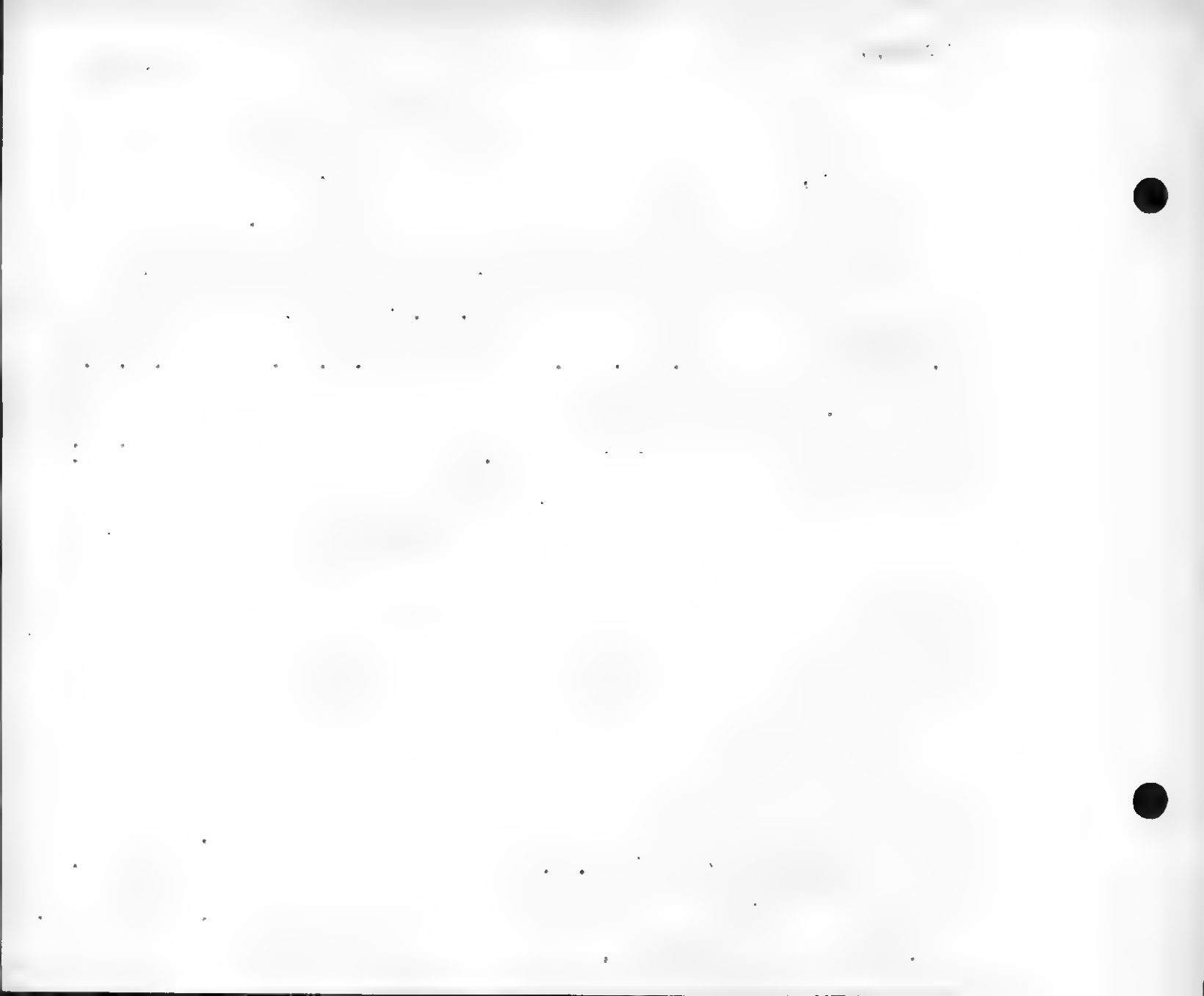
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13230

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13232

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
c. LENGTH OF STAY In <u>5</u> days		d. STREET ADDRESS <u>833 Columbia Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arley</u> Middle <u>Delbert</u> Last <u>Sherman</u>		4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 21, 1889</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. boilermaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. Rwy.</u>	
11. BIRTHPLACE (State or foreign country) <u>Barbour Co. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William E. Sherman</u>		14. MOTHER'S MAIDEN NAME <u>Catharine Bolyard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>705-12-4708</u>	
17. INFORMANT <u>Mrs. Gilbert Markwood</u>		Address <u>Cumb. Md. 833 Columbia Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>17.5</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 8)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M. D.</u>		22. DATE SIGNED <u>Oct. 30, 1967</u> Address (Street, city, town or county) <u>Cumberland, Md.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Cumberland, Allegany Md.</u>
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	
25a. REC'D BY REGISTRAR DATE <u>NOV 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18

13231

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13233

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 36 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 133 1/2 N. CENTRE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DELICIE S. SMITH		4. DATE OF DEATH Month 10 Day 17 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-09
9. AGE (In years last birthday) 58 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR	
11. BIRTHPLACE (County & State, or foreign country) ELK GARDEN, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES H. SOLLARS		14. MOTHER'S MAIDEN NAME ELIZABETH (MURPHY)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 219-03-8787	
17. INFORMANT SACRED HEART HOSPITAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC-RENAL FAILURE 1510 DUE TO (b) METASTASIS OF CARCINOMA DUE TO (c) CARCINOMA OF STOMACH ADVANCED 201146 NOV 115	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-2-67, 19 67 , to 10-17, 19 67 , that (I) (we) last saw the deceased alive on 10-16-1967 , and that death occurred at 1 M, from causes and on the date stated above.			
22a. SIGNATURE Richard Schindler M.D.		22b. DATE SIGNED OCT 22 1967	
22c. PHYSICIAN'S NAME (Type) DR. R. SCHINDLER		22d. ADDRESS 69 GREENE ST., CUMB., MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-19-67	23c. NAME OF CEMETERY OR CREMATORY Hartmansville Family	23d. LOCATION (City or Town) (County) (State) ELK GARDEN Mineral W.Va.
24. FUNERAL DIRECTOR PRITTS FUNERAL HOME, KITZMILLER, MARYLAND		25a. REC'D BY REGISTRAR OCT 26 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24-hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on all completely filed copies by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72-hours after death.

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20 M 1/66

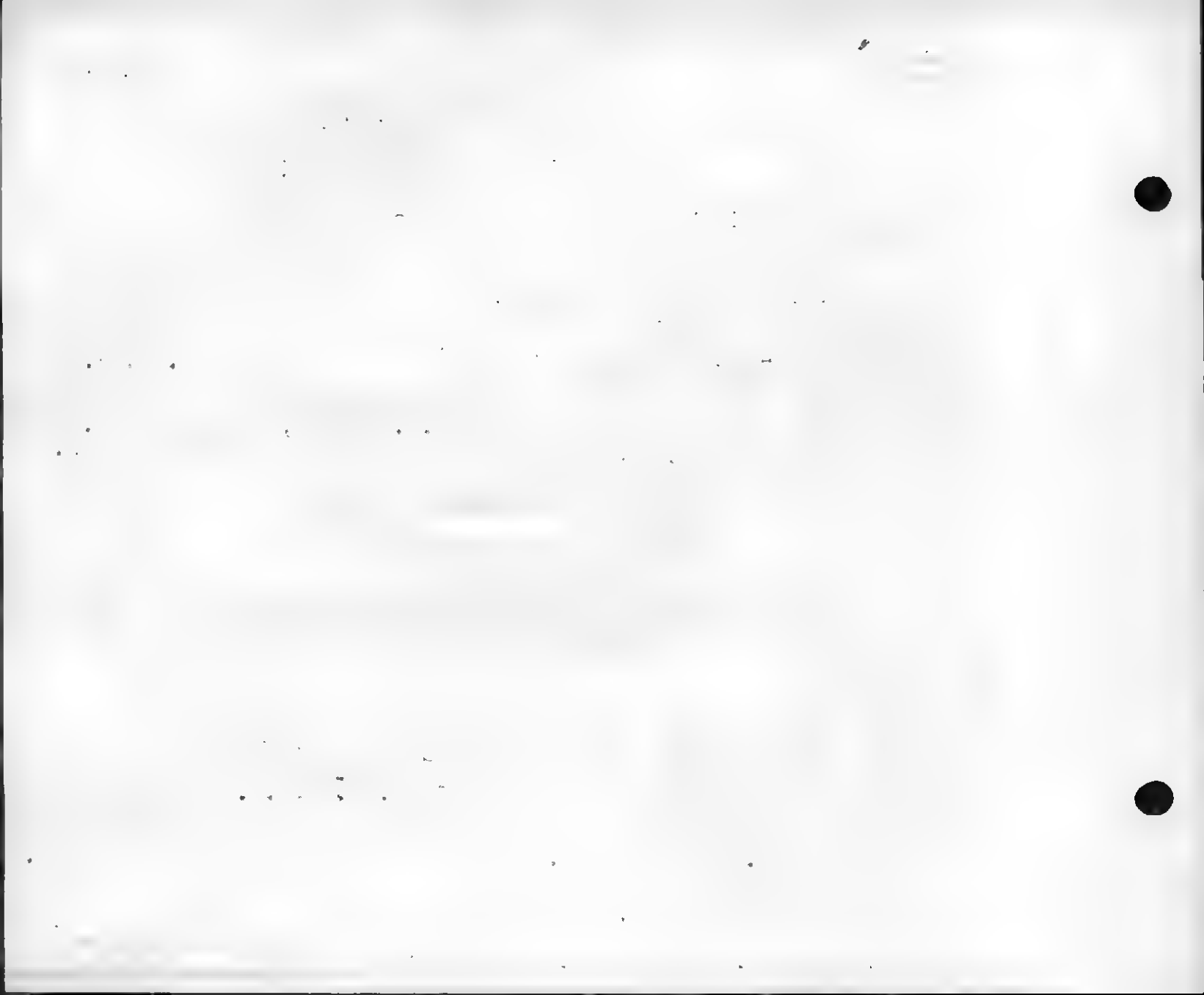
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13232

CERTIFICATE OF DEATH

13231

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB 12/2/1963	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. STREET ADDRESS 147 Polk Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Margaret Last Smith		4. DATE OF DEATH Month October Day 23 , Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/1887
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Presser-Sanford Cleaning Establishment		11. BIRTHPLACE (County & State, or foreign country) Ohio	
12. CIT. ZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME David Twigg	
14. MOTHER'S MAIDEN NAME Martha Ellen Pittman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-05-6985		17. INFORMANT P.O. Box 599, Cumberland, Md. 21502 Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cerebro-vascular accident DUE TO (b) Acute C.V.A. & Hemiplegia, Rt. DUE TO (c) Arterio-Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 4 yrs many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Arterio Sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/2/63 , 19__, to 10/23/67 , 19__, that (I) (we) last saw the deceased alive on 10/23/67 , 19__, and that death occurred at P. M. , from causes and on the date stated above.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED 10/24/1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/26/1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery	23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR OCT 27 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13233

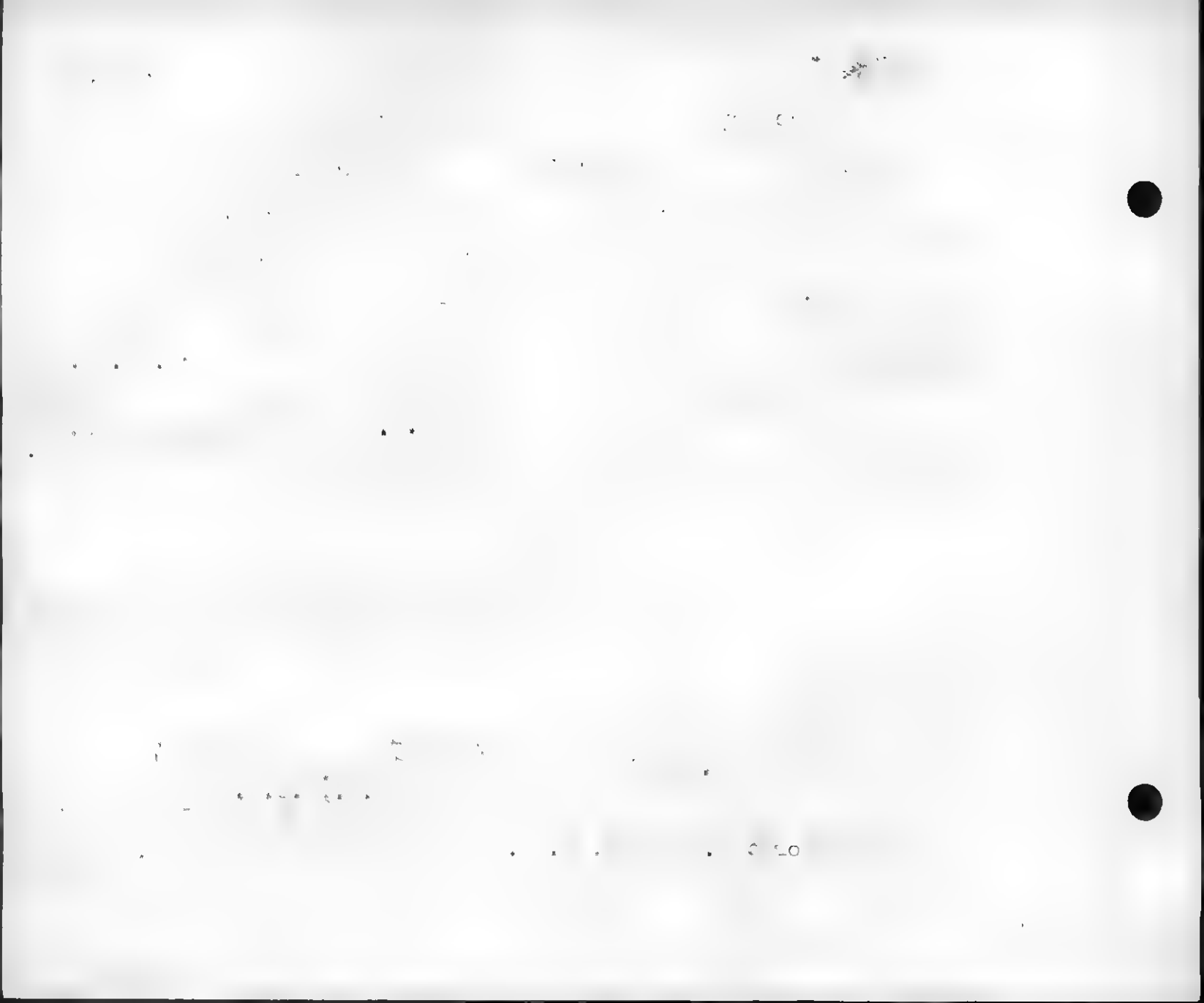
CERTIFICATE OF DEATH

13235

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b 6/9/1965			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 106 Decatur Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Myrtle Last Steele		4. DATE OF DEATH Month October Day 18 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/1883
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months 1 Days 18 Hours 18 Min 18	11. IF UNDER 24 HRS Hours 18 Min 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland Saxton, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob College		14. MOTHER'S MAIDEN NAME Margaret McLane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599, Cumberland, Md.		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Myocarditis DUE TO Gen. Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/9/1965 , 19 to 10/18/1967 , that (I) (we) last saw the deceased alive on 10/17/67 19 and that death occurred at P.M. from causes and on the date stated above			
22a. SIGNATURE George M. Simons, M. D.		22b. DATE SIGNED 10/18/1967	
22c. PHYSICIAN'S NAME (Type) George M. Simons, M. D.		22d. ADDRESS Memorial Hospital, Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/20/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.		25a. REC'D BY REGISTRAR OCT 23 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all pages. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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13234

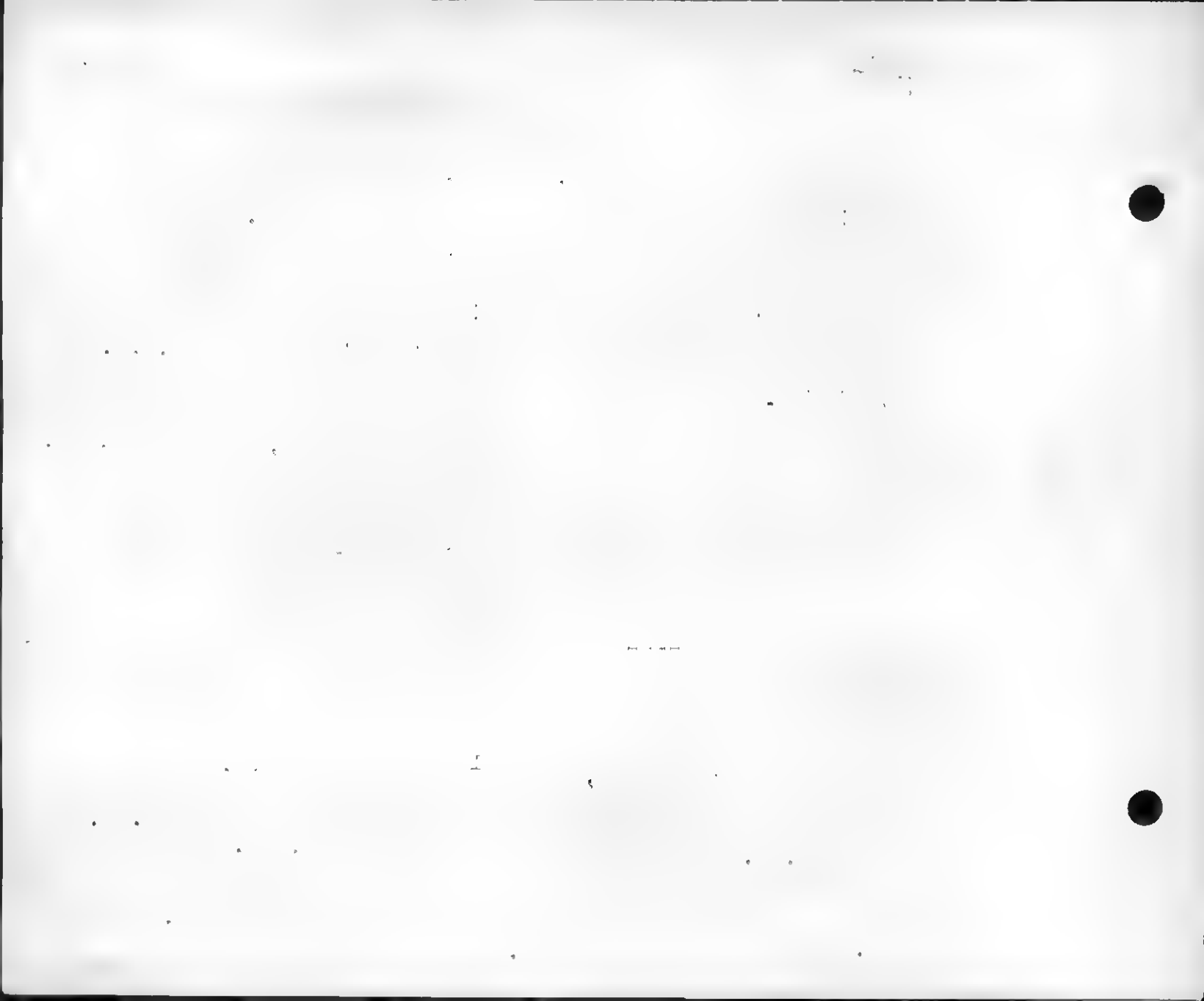
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13236

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN IT 11 HRS. 30 MIN.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d STREET ADDRESS 402 SOUTH ST.	
3 NAME OF DECEASED (Type or print) First BESSIE Middle P Last STEWART		4 DATE OF DEATH Month OCTOBER Day 25 Year 67	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-9-90
9 AGE (In years lost birthday) yrs 77		10. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Housewife	
10b KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (County & State or foreign country) VIRGINIA-Timberville	
12 CITIZEN OF WHAT U.S.A.		13. FATHER'S NAME WILLIAM H. MILLER	
14. MOTHER'S MAIDEN NAME JANE TURNER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16 SOCIAL SECURITY NO		17 INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4221 DUE TO (b) Arteriosclerotic Cardio-vascular Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture right Hip---Diabetes Mellitus			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office b-dg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1954 , 19 10:40 P.M. , 19 67 , that (I) (we) last saw the deceased alive on October 25, 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. G. O. Himmelwright</i>		22b DATE SIGNED Oct. 27, 1967	
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22d. ADDRESS CUMBERLAND, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Oct. 28, 1967	23c NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE OCT 30 1967	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



CERTIFICATE OF DEATH

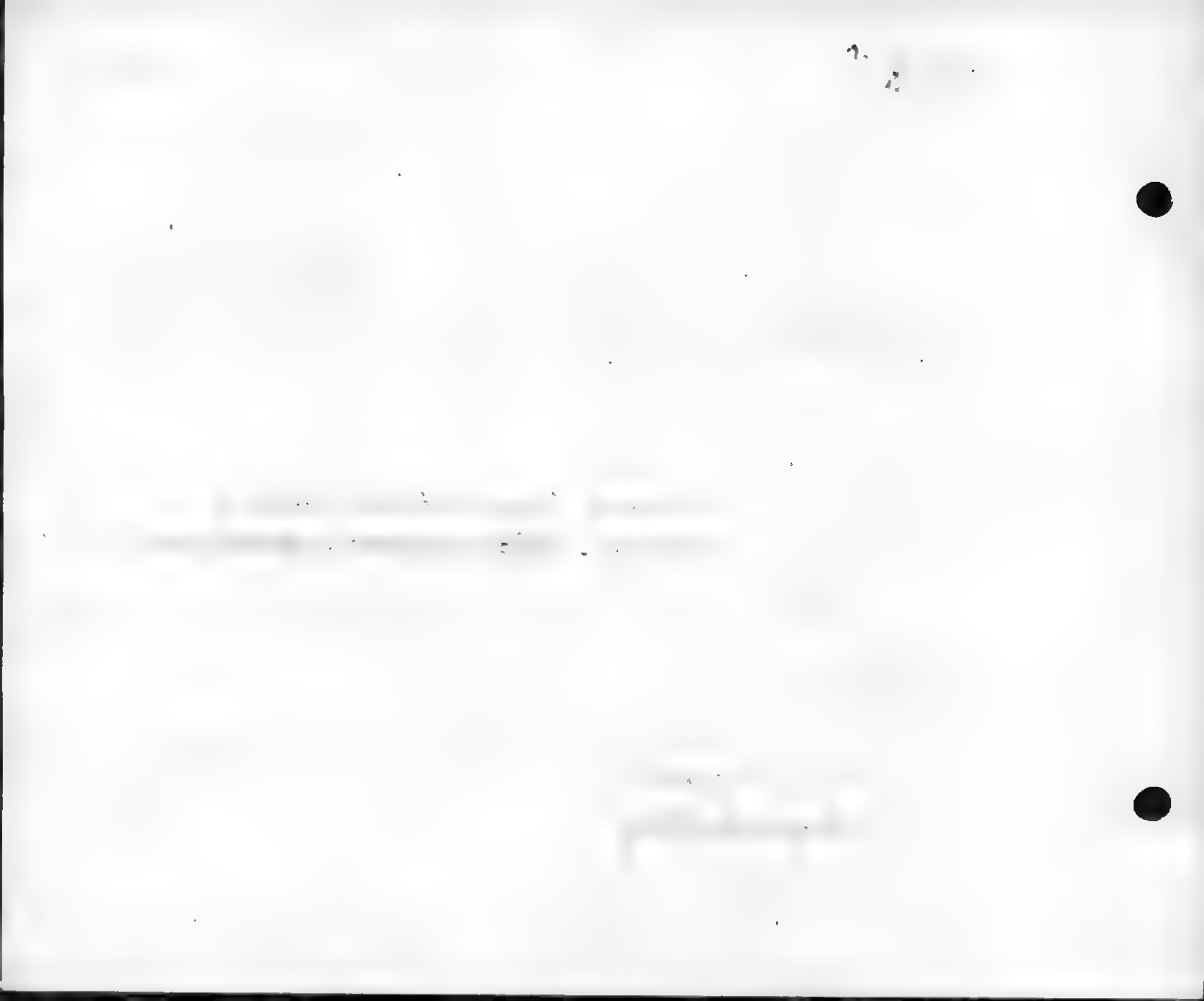
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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
c. LENGTH OF STAY IN Yr 60 YEARS		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 168 WEST MAIN STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 168 WEST MAIN STREET	
3. NAME OF DECEASED (Type or print) JULIA TACCINO		4. DATE OF DEATH Month OCTOBER Day 29 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 24, 1891
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 6 Days 00 Hours 00 Min.	
10a. OCCUPATION (Give kind of work done during most of work life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State or foreign country) PROVINCE OF SPEZZANO, COSANZO, ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL CIVIGLIANO		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO N.A.		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MRS. VERA PIFALO		17. ADDRESS FROSTBURG, MARYLAND 174 WEST MAIN STREET	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDIAL FAILURE DUE TO (b) CHRONIC ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 6 mos.			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/27, 1967 , to 10/29, 1967 , that (I) (we) last saw the deceased alive on 10/29, 1967 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED 10/30/67	
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M.D.		22d. ADDRESS 167 E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 2, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY	23d. LOCATION (City or town) (County) (State) FROSTBURG, MARYLAND
24. FUNERAL DIRECTOR CHARLOU D. SOVERS, HAFFER-SOVERS FUNERAL HOME, 60 W. MAIN, FROSTBURG		25a. REC'D BY REGISTRAR NOV 3 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13236

CERTIFICATE OF DEATH

13238

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 26 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 2327 DUKE ST., APT. E33	
3. NAME OF DECEASED (Type or print) First JANET Middle H. Last TEDDER		4. DATE OF DEATH Month OCTOBER Day 4 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-38
9. AGE (In years last birthday) 29 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASST. TRAVEL DIRECTOR		10b. KIND OF BUSINESS OR INDUSTRY TRAVEL AGENCY	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD., ALLEGANY		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME STANLEY HANNA		14. MOTHER'S MAIDEN NAME MADGE LIGHT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 234 58 1501	
17. INFORMANT HOSP. RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LUPUS NEPHRITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LUPUS ERYTHEMATOSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 mo			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-8, 19 67 , to 10-4, 19 67 , that (I) (we) last saw the deceased alive on 10-4 19 67 , and that death occurred at 8:30 AM , from causes and on the date stated above.			
22a. SIGNATURE L. Michael Gluck		22b. DATE SIGNED 10-5-67	
22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLUCK		22d. ADDRESS 126 N. SMALLWOOD ST	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10/7/67	23c. NAME OF CEMETERY OR CREMATORY Philos Cem.	23d. LOCATION (City or town) (County) (State) Westernport, Md.
24. FUNERAL DIRECTOR BOAL'S FUNERAL HOME		25a. REC'D BY REGISTRAR DCT 9 1967	
ADDRESS 111 CHURCH ST.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13237

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13239

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 14 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SAC RED HEART HOSPITAL				d. STREET ADDRESS 654 NATIONAL HIGHWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCESCA Middle H. Last TEPPER				4. DATE OF DEATH Month OCTOBER Day 5 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03-28-03		9. AGE (In years last birthday) 64 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PHILADELPHIA, PENNA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES E. HANNA				14. MOTHER'S MAIDEN NAME Frances DUFRESNE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT HOSP. RECORD Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Rupture + Tamponade DUE TO (b) Arteriosclerotic + Coronary Art Dis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 7 years
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Advanced Adenoca of Ascending Colon							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from 9-12 , 1967, to 10-5 , 1967, that (I) (we) last saw the deceased alive on 10-5 , 1967, and that death occurred at 7:30PM , from causes and on the date stated above.							
22a. SIGNATURE A. J. Mirkin				22b. DATE SIGNED _____		22c. PHYSICIAN'S NAME (Type) Dr. A. J. MIRKIN	
22d. ADDRESS 115 So. Centre - Cumberland 126 N. W. 11th St., CUMBERLAND, MD.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 10/9/67		23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Garden Cumberland MD		23d. LOCATION (City or Town) _____ (County) _____ (State) _____	
24. FUNERAL DIRECTOR LOUIS STEIN, INC.				25a. RECEIVED BY REGISTRAR OCT 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
117 FREDERICK ST. CUMBERLAND, MD. 21502							

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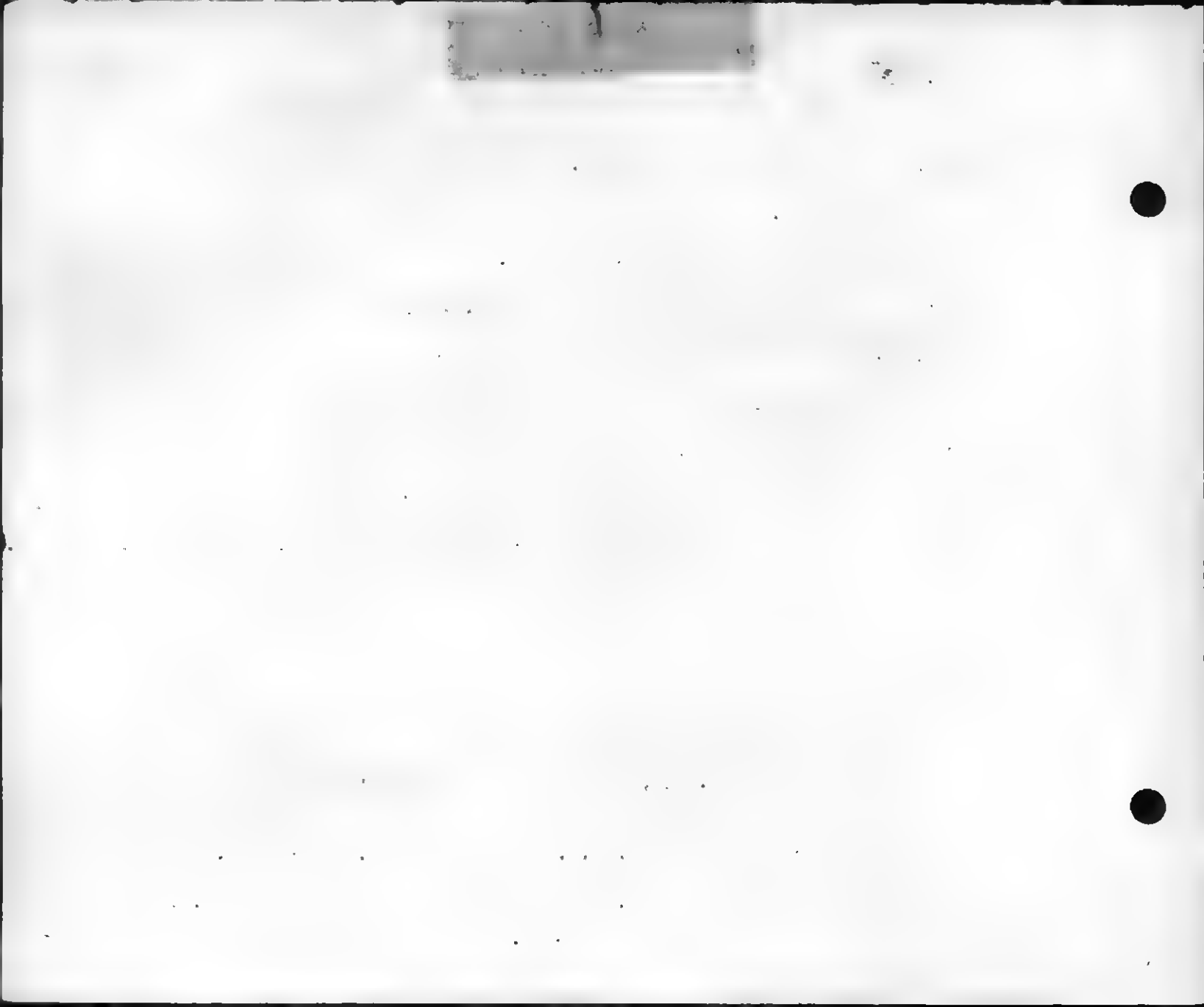
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Allegheny</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Luke</u>		c. LENGTH OF STAY IN 1b <u>46 yrs.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Luke</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Manuel Quiros Tuya</u>						4. DATE OF DEATH Oct. <u>15</u> 19 <u>67</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 1, 1894</u>		9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Spain</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Alvaro Quiros</u>						14. MOTHER'S MAIDEN NAME <u>Carmen Tuya</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>214 32 3048</u>		17. INFORMANT <u>Gloria Tuya Dunn</u>		Address <u>Reese, Mich.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sequella of operation for cholelithiasis.</u> DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 5</u> , 19 <u>67</u> , to <u>10/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct. 15</u> , 19 <u>67</u> , and that death occurred at <u>3:30 p</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>James Wolverton Sr. M.J.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/16/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>James Wolverton Sr. M.J.</u>						22d. ADDRESS <u>Green St. Piedmont, W. Va.</u>					
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>10/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>		23d. LOCATION (City, town or county) (State) <u>Westernport, Md.</u>			
24. FUNERAL DIRECTOR <u>[Signature]</u>						ADDRESS <u>Westernport, Md.</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13238

CERTIFICATE OF DEATH

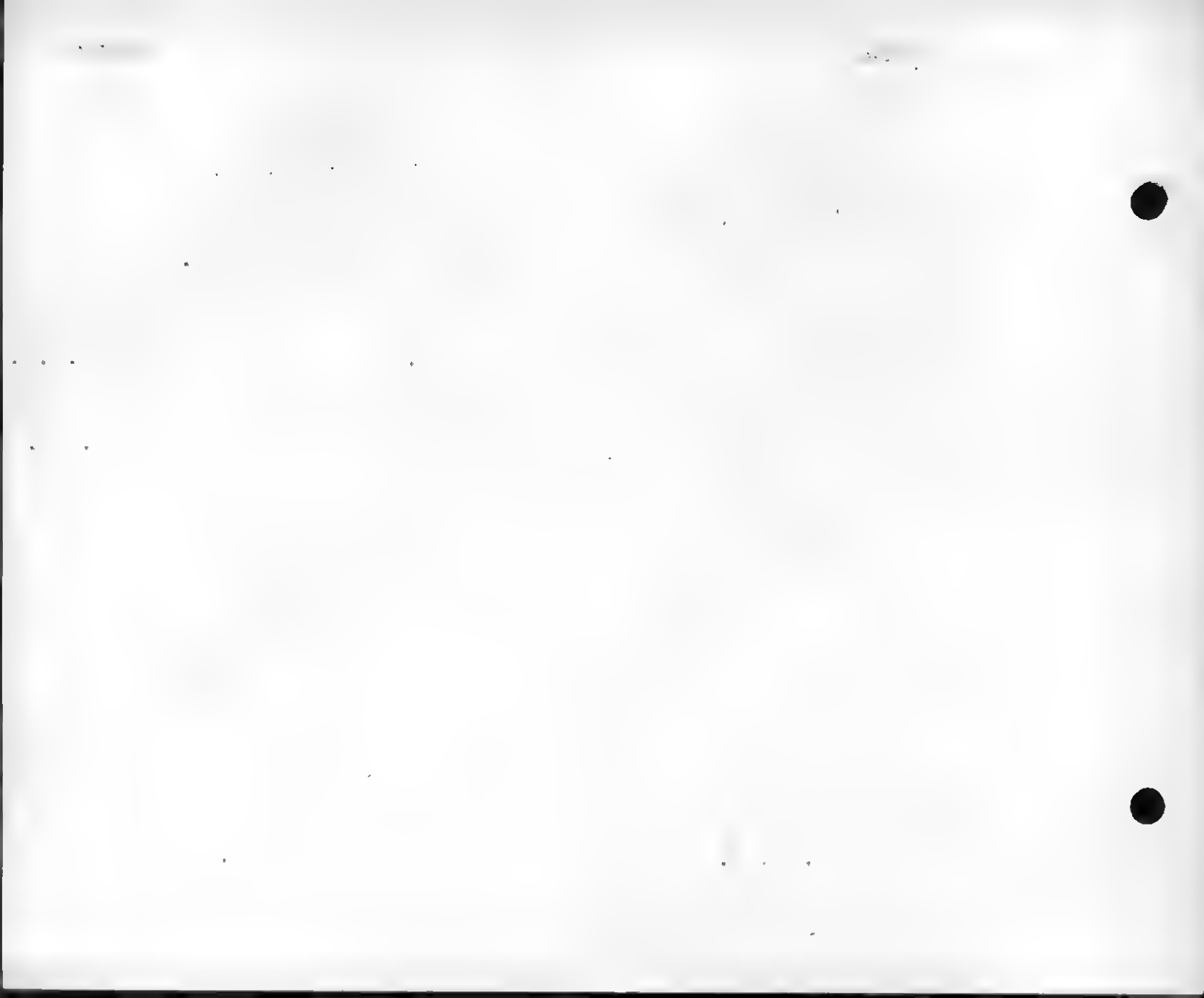
13241

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE		c. LENGTH OF STAY IN 1b 40 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 422 NATIONAL HIGHWAY		d. STREET ADDRESS 422 NATIONAL HIGHWAY	
3 NAME OF DECEASED (Type or print) RUSSELL S. WAGNER		4 DATE OF DEATH Month OCT. Day 6 Year 19 67	
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH DEC. 15, 1906
9. AGE (n years last birthday) yrs 60		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10b. KIND OF BUSINESS OR INDUSTRY BANKING	
11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PETER H. WAGNER		14. MOTHER'S MAIDEN NAME MARGARET SHERRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 2		16. SOCIAL SECURITY NO. 217 14 4151	
17. INFORMANT MRS. DOROTHY WAGNER		Address LA VALE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized metastatic DUE TO (b) Bronchogenic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 16 x 1			INTERVAL BETWEEN ONSET AND DEATH 3 mo 13 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/6 , 19 66 , to 10/6 , 19 67 , that (I) (we) last saw the deceased alive on 10/6 , 19 67 , and that death occurred at 9 P M, from causes and on the date stated above.			
22a. SIGNATURE R. Rhett Rathbone		22b. DATE SIGNED OCT. 7, 1967	22c. PHYSICIAN'S NAME (Type) R. RHETT RATHBONE, M.D.
22d. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 9, 1967	23c. NAME OF CEMETERY OR CREMATORY REST LAWN MEM. GARDENS	23d. LOCATION (City or Town) (County) (State) CUMBERLAND MARYLAND
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR OCT 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13241

13243

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 3 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			d. STREET ADDRESS ROUTE #1 BOX 127		
3. NAME OF DECEASED (Type or print) First Middle Last VIRGINIA SAYVILLE WHITE			4. DATE OF DEATH Month Day Year OCTOBER 21 19 67		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-31-15		9. AGE (In years lost birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) ALLEGANY CTY., MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME COLUMBUS MILLER			14. MOTHER'S MAIDEN NAME WM WHITTINGTON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 215-26-9975	17. INFORMANT HOSP. RECORD Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Coronary Artery Disease stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH unk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Anemia					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 10/18, 1967 , to 10/21, 1967 , that (I) (we) last saw the deceased alive on 10/21 1967 , and that death occurred at 2:40 PM , from causes and on the date stated above.					
22a. SIGNATURE [Signature]			22b. DATE SIGNED 10/23/67		
22c. PHYSICIAN'S NAME (Type) J. A. PABAN, M. D.			22d. ADDRESS 5 POTOMAC ST., RIDGELEY, W. VA.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/25/67	23c. NAME OF CEMETERY OR CREMATORY Philos	23d. LOCATION (City or town) (County) (State) Westernport Md.		
24. FUNERAL DIRECTOR ELLSWORTH BOAL ADDRESS WESTERNPORT, MD.			25a. REC'D BY REGISTRAR OCT 26 1967	25b. REGISTRAR'S SIGNATURE [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

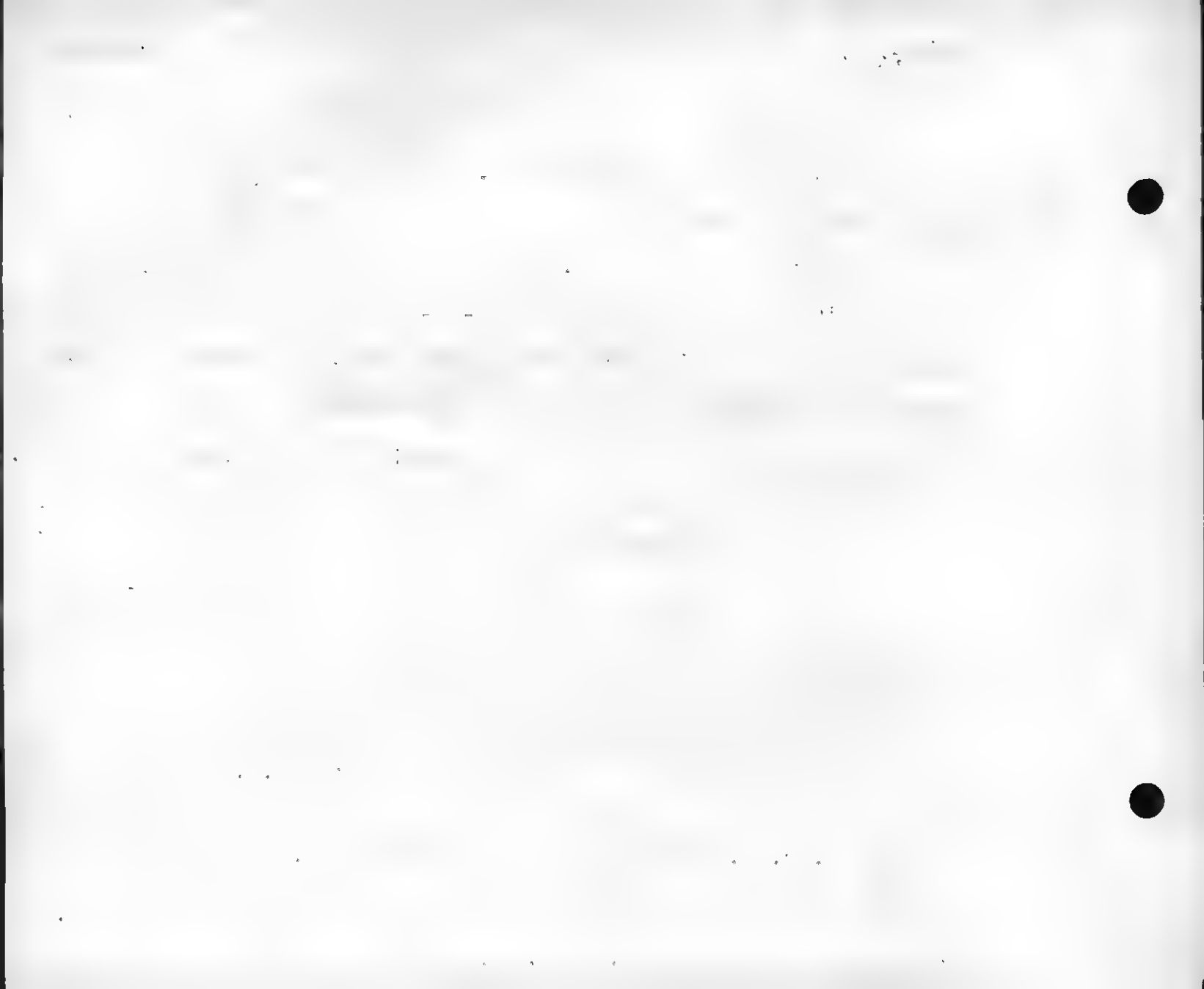
13242

13244

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS 5HRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS RT. #2, DEHAVEN ROAD	
3 NAME OF DECEASED (Type or print) CHARLES N. WILKINSON		4. DATE OF DEATH OCTOBER 2, 1967	
5. SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-1898
9 AGE (in years last birthday) 69 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER	
10b. KIND OF BUSINESS OR INDUSTRY LIQUOR STORE		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND	
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES N. WILKINSON	
14. MOTHER'S MAIDEN NAME CLARA BREEDING		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 214-07-0782		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 443x IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertensive Arterio Sclerosis DUE TO (c) Cardio Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-29-1967 to 10-2-1967 that (I) (we) saw the deceased alive on 10-1-1967 and that death occurred at 4:25 AM at Home and on the date stated above.			
22a. SIGNATURE W. F. Williams MD		22b. DATE SIGNED 10.2.67	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.
24. FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR OCT 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

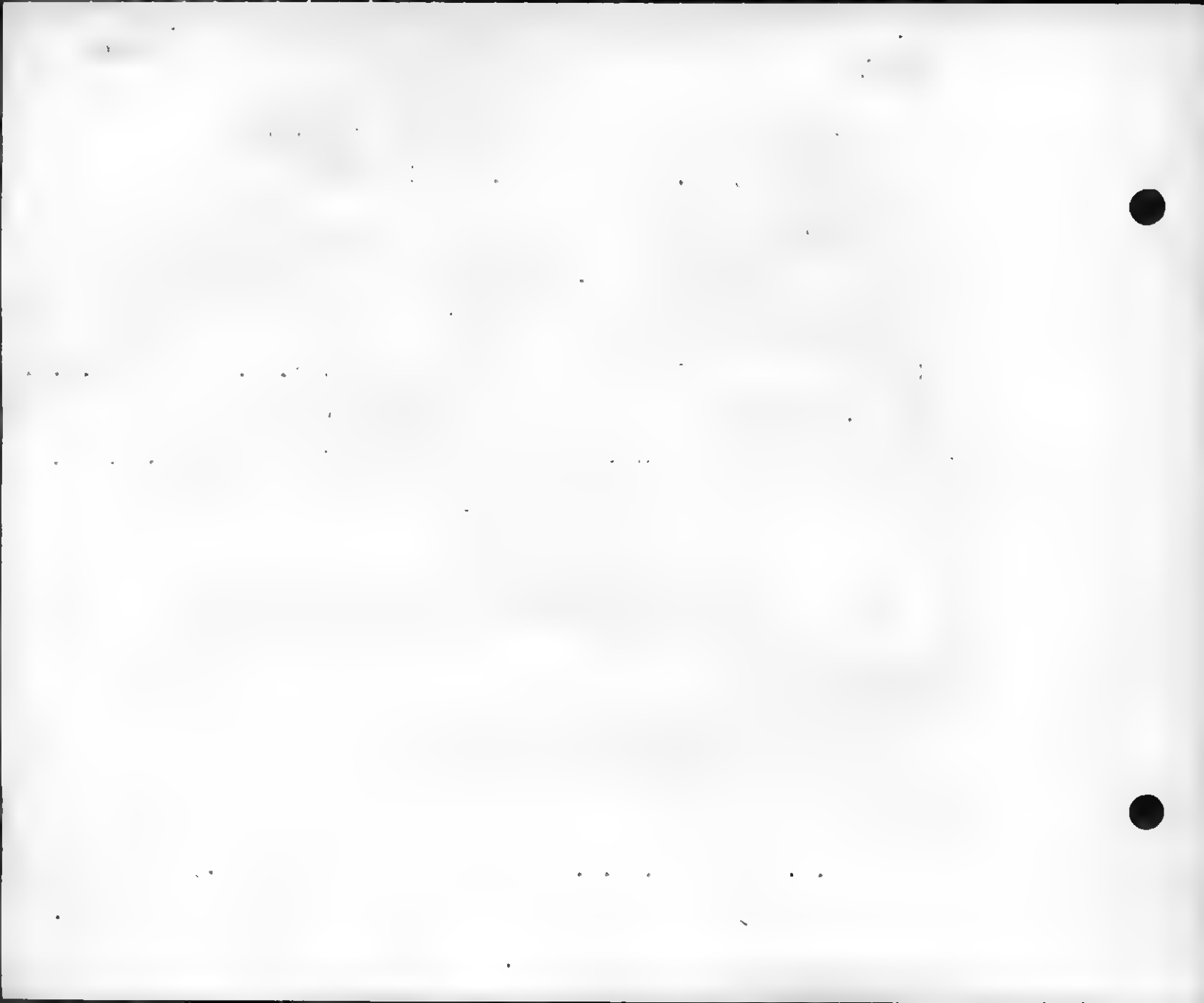
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13245

13243

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE WEST VIRGINIA b COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 3HR 25 MIN.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 26 GREEN STREET	
3 NAME OF DECEASED (Type or print) First GERALDINE Middle L. Last WILKINSON		4. DATE OF DEATH Month OCTOBER Day 20 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MARCH 5, 1926
9. AGE (In years last birthday) 41 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11 BIRTHPLACE (County & State, or foreign country) MORGANTOWN, W. VA.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES P. WILKINSON		14. MOTHER'S MAIDEN NAME ELIZABETH BERRENS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 213-22-3047	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure DUE TO (b) Cancer (Pulmonary) DUE TO (c) Carcinoma lung (massive) Breast 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 49 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 to 20 Oct , 1967, that (I) (we) last saw the deceased alive on 20 Oct , 1967, and that death occurred at 8:10 PM from causes and on the date stated above			
22a. SIGNATURE F. B. Whitworth		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) F. B. WHITWORTH, M.D.		22d. ADDRESS 305 WASHINGTON ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 23 10/23/67	
23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City or Town) (County) (State) Westernport Md.	
24. FUNERAL DIRECTOR Westernport, Md.		25a. REC'D BY REGISTRAR OCT 24 1967	
25b. REGISTRAR'S SIGNATURE Michael J. Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13244

CERTIFICATE OF DEATH

13246

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c LENGTH OF STAY IN b 8 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS RT 1 BOX 151 A		
3 NAME OF DECEASED (Type or print) First ARCHIE Middle EARL Last WINTERS			4 DATE OF DEATH Month OCTOBER Day 5 Year 1967		
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-16-1898	9. AGE (In years last birthday) 69 yrs	10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER			11b KIND OF BUSINESS OR INDUSTRY COAL		
12 BIRTHPLACE (County & State, or foreign country) CARLOS, MD.			13 CITIZEN OF WHAT COUNTRY? U.S.A.		
14 FATHER'S NAME WILLIAM WINTERS			15 MOTHER'S MAIDEN NAME ELIZABETH DENSMORE		
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N.A.			17 SOCIAL SECURITY NO 214-01-6732		
18 CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma right lower bronchus DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			19 INTERVAL BETWEEN ONSET AND DEATH ?		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastasis to bone, Anthrosilicosis, Uremia, Coronary Arteriosclerosis.					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Aug. 30, 1965, 2:25 P.M. to 10/5/67 , that (I) (we) last saw the deceased alive on 10/5/67 19____, and that death occurred at 5/25/67 from causes and on the date stated above.					
22a SIGNATURE <i>Samuel M. Jacobson</i>			22b DATES SIGNED 10/7/67		
22c PHYSICIAN'S NAME (Type) SAMUEL M. JACOBSON			22d ADDRESS CUMBERLAND, MD.		
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF OCT. 8, 1967		23c NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK	
23d LOCATION (City or town) (County) (State) FROSTBURG MARYLAND		23e REC'D BY REGISTRAR OCT 9 1967		23f REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24 FUNERAL DIRECTOR MARLENE M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13245		CERTIFICATE OF DEATH				13247			
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 8/1/1967		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ALLEGANY COUNTY INFIRMARY					d. STREET ADDRESS 95 Ormond St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Martha Witchell			First Middle Last		4. DATE OF DEATH Month October Day 1 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/14/1886		9. AGE (In years last birthday) yrs. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mr. Henry Filer					14. MOTHER'S MAIDEN NAME Martha Green				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N.A.			16. SOCIAL SECURITY NO. NONE		17. INFORMANT P.O. Box 599 Cumberland, Md. ALLEGANY COUNTY INFIRMARY Records.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Acute renal insufficiency DUE TO Chc A.S.H.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) many years DUE TO (c) Arterio-sclerosis many years									INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diuitz Lowcutia									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8/1/1967 , 19____, to 10/1/1967 , that (I) (we) last saw the deceased alive on 10/1/1967 , and that death occurred at 1:12 P.M. 057 M, from causes and on the date stated above.									
22a. SIGNATURE Dr. John Topper					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 10 / 2 / 1967	
22c. PHYSICIAN'S NAME (Type) Dr. John Topper					22d. ADDRESS Memorial Hospital Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		23d. LOCATION (City or Town) (County) (State) Frostburg, Allegany, Md.			
24. FUNERAL DIRECTOR Marion M. Sowers					25a. REC'D BY REGISTRAR 160 W. Main, Frostburg, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge		

11

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13246

13248

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN It 9 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital--DOA			d. STREET ADDRESS Route 4, Oldtown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Linda Middle Jean Last Woods			4. DATE OF DEATH Month Oct. Day 17 Year 1967		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 28, 1957		9. AGE (In years last birthday) yrs. 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Elementery School		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
13. FATHER'S NAME Charles C. Woods			14. MOTHER'S MAIDEN NAME Eleanor Whitaker		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mother Mrs. Eleanor Woods, Rt. 4, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Cervical Vertebrae Crushed Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (Ran into side of Automobile) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran into side of moving vehicle			
20c. TIME OF INJURY Month, Day, Year 3:55 p.m. Oct. 16 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Rt. 51 0.2 miles East Cumberland, All, Md.	
20f. (City or town) (County) (State) Cumberland, Md. Allegany					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarellic		M.D.		22. DATE SIGNED October 16, 1967	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 19, 1967	23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE OCT 20 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1937

Allegany

Admission

Admission Fee--\$1.00

Kind

Year

Admission

Admission

Admission Fee--\$1.00

Kind

Year

Nov. 2, 1937

Admission Fee--\$1.00

Admission Fee--\$1.00

Admission Fee--\$1.00

Year

Admission Fee--\$1.00

Admission Fee--\$1.00

Admission Fee--\$1.00

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Admission Fee--\$1.00

Year

Admission Fee--\$1.00

Admission Fee--\$1.00

Admission Fee--\$1.00

Admission Fee--\$1.00

Admission Fee--\$1.00

Admission Fee--\$1.00